Consumers Health Forum of Australia

SUBMISSION

# CHF Submission on the National Safety and Quality Primary Health Care Standards

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Consumers Health Forum of Australia 2021
*CHF Submission on the National Safety and Quality Primary Health Care Standards*

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# Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the diverse interests of Australian healthcare consumers and those with an interest in health consumer affairs. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems. We are pleased to provide this submission on the draft National Safety and Quality Primary Health Care (NSQPH) Standards.

Our positions are developed through consultations, research, and events like the Thought Leadership Roundtables involving consumers, health care providers, policy experts, academics and people in government. Further information about us and our publications can be found on our website, www.chf.org.au.

We have sought input on this submission from our members and consumer networks including our Safety and Quality and Primary Health Care Special Interest Groups and have drawn on their input in preparing this response.

# General Comments

CHF supports the intent and the development of the NSQPH Standards to protect the public from harm and improve the quality of care delivered across a broad range of primary health care settings. The Standards are also an important way to provide transparency for consumers and service providers about the expected standards of safety and quality that should be met and the ongoing requirement for continuous quality improvement.

Primary health care covers a wide range of services, including general practice, dentistry, nursing, midwifery, optometry, pharmacology, physiotherapy, podiatry, psychology and more. The Standards need to be broad in order to cover the range of services and environments that may be covered.

While this breadth allows for flexibility, it does make it more difficult to provide clarity for consumers on the application, implementation, accreditation and incentivisation of these standards. Consultation with CHF's consumer networks identified some confusion about which services these Standards would apply to and how they will align or overlap with other existing health service standards.

In order to maximise uptake of the NSQPH Standards and to ensure they provide accurate and relevant information to improve health outcomes and experiences, CHF believes it is important that any potential overlap with other existing standards is minimised. This includes minimising the administrative burden associated with gaining accreditation against multiple sets of standards. Simplifying the accreditation process is beneficial for both service providers and consumers and gives clarity about what standards the services are meeting.

CHF is pleased to see that the ACSQHC is planning to develop a series of resources to support providers to implement the NSQPH Standards. We would also support the development of consumer resources to clearly explain the purpose of these Standards, how

they align with other existing standards and how consumers can find out if a service they are attending is accredited.

We would ask the Commission to consider the role of Primary Health Networks in both upholding and raising awareness of the Standards. They have a critical role supporting primary health care providers yet the scope of their role, if any, has not been canvassed.

Another key question raised by consumers was about the voluntary nature of the NSQPH Standards and what incentives would exist for private providers to be accredited and comply. Consumers felt it was important for the Standards to be linked to eligibility for public funding and wanted to see this gradually introduced over time. This would be a clear demonstration by governments that safety and quality is valued as a key aspect of providing health care to the community.

# Response to the Consultation Paper

## *Introduction*

While the introduction provides some context for the Standards, as noted previously consumers remained somewhat confused about how these standards fit alongside the range of other standards that already exist and that many practices are already accredited against.

We support efforts to link the standards to funding and other key requirements to give them meaning and purpose and many consumers expressed a desire to see the standards go beyond a voluntary approach. The implementation of the Standards provides an opportunity to raise awareness and embed a culture of safety, quality and improvement across primary health care. However, it is equally important to reduce the cost and time burdens on practices, especially small providers, who often need to be accredited against multiple sets of standards e.g. NDIS, profession-specific, aged care etc. Ensuring consistency of these standards with others and linking accreditation processes could help in this regard.

Further clarity is also needed around the process for consumers to raise concerns where a service is not complying with the Standards, including links to relevant dispute resolution processes through ombudsmen and health service commissioners across each state and territory. Additionally, from the consumer perspective, the following aspects should be incorporated into the implementation of the Standards:

- Consumers should be involved in the accreditation process, as they are for hospitals and day services
- ACSQHC should develop transparent public information about which services have been accredited against the standards to help inform consumer decisions about which services they access
- ACSQHC should develop clear, concise communication materials for consumers to understand what the standards are and how they fit alongside the range of other accreditation standards that health services are required to meet (noting this is a lengthy document that is likely to be inaccessible to many consumers).

## *Appropriateness*

The NSQPH Standards cover the key safety and quality issues in primary health care. In order to ensure the Standards remain up to date with changes in practice and changes in community attitudes we suggest an annual review process to update the Standards in line with emerging evidence.

CHF would also like to see the Standards have a greater focus on the adoption of digital technologies to facilitate care, maintain patient records and record adverse events. While digital health is not a replacement for face-to-face care, as technology improves it should be provided as an option for the consumer to choose. Digital health presents its own safety and quality challenges, particularly with regard to privacy, communication style and understanding what can be done safely through a digital medium. The Strategy makes some reference to these issues but they could be highlighted more strongly noting the increasing prevalence and use of digital approaches.

## *Actions*

Broadly CHF believes the actions as outlined are appropriate and make sense. CHF suggests the following changes to specific actions:

- 1.01a. – 'a culture of safety and quality improvement' is a vague concept. We suggest amending this to 'incorporates a commitment to safety and quality in its organisation's purpose, values and clinical governance framework.'
- 1.01f. – add 'on a regular basis'
- 1.07b. – suggest change to clinicians or health care providers to be clearer about who 'their' refers to
- 1.15 – change to 'culturally safe and appropriate services that are free from racism and discrimination'
- 1.23 – this action should be limited to a focus on physical access to a facility, with a separate action included about easily accessible interface for telehealth or other digital services (combining the two into one action is confusing and conflates different issues)
- 2.01 – this action needs expanding to explain how safety and quality systems should be used to support partnering with patients
- 2.04b – alongside the role of substitute decision makers, the action should also recognise any care directives the patients may have made in the event that they do not have decision making capacity, such that health professionals should provide care in line with those directives
- 2.07 – add the word 'respectful' to part a) and amend b) to 'ensures the patient comprehends and can retain key information after the consultation'. This is important with the standards pushing greater shared responsibility for care planning and partnerships.
- 2.09 – suggest including reference to the collection of Patient Reported Experience Measure (PREM) data as one way of assessing patient experience
- 3.08 – from the consumer perspective it is not sufficient to merely document where a healthcare worker refuses vaccination as this continues to pose a safety risk to patients. Depending on their role, some health professionals should be required to be vaccinated in order to be able to continue treating patients.

- 3.12c – add 'including adding the medicines list to the patient's My Health Record where the patient consents'
- 3.13 – wording to be amended to make it clear that the practice has an obligation to report any adverse drug reaction to the TGA. If the notification is not in scope for a particular provider the practice should have a clear process in place to ensure that the report is made by the appropriate person
- 3.16 – add an additional point: "has processes in place to securely share information with other health service providers with the patient's consent"
- 3.18 – add in an additional point on 'identifying any previous plans or directives the patient has developed with other providers and ensure the care plan aligns with the patient's wishes'
- 3.22 – suggest inclusion of a link to the National Suicide Prevention Strategy and other appropriate resources in the explanatory notes
- 3.26 – need to clarify if this point relates to communication with the patient about a proposed referral, or communication with the health care provider being referred to (or both). When communicating with the patient, barriers to accessing the referral including transport and cost should be considered and alternatives proposed if needed.

## *Language*

CHF believes the language in the Standards is understandable and appropriate, for health professionals and service providers. However, we note the length of the document and density of the text will make the document inaccessible for some members of the community, particularly those with low levels of health literacy. Summary communication materials should be developed to explain the purpose of the standards to a wider audience. This should include multimedia such as infographics and short video explainers.

In some sections the document lists groups of health professionals as examples of who the Standards are applicable to. This is potentially problematic as it draws attention to some professions and misses others. We suggest the Strategy should reference the broad categories of medical, nursing and allied health professionals working in community settings as a more comprehensive approach as this avoids potential confusion where some professions are not listed but may provide services within scope of the Standards.

Additionally, the Standards rightly identify the specific needs of Aboriginal and Torres Strait Islander people throughout. The document should also include recognition of the unique needs and barriers of other specific population groups including people from culturally and linguistically diverse (CALD) backgrounds and people with a disability. The specific needs of isolated, aged and/or disabled patients should be noted regarding the need for home-based care and outreach.

## *Not applicable actions*

Broadly CHF believes the non-applicable actions as outlined are appropriate and make sense. CHF suggests the following changes to specific actions:

- 1.12 and 1.13 – while noting that certain actions won't apply to practices that do not use My Health Record, we suggest that the decision not to use My Health Record should be

noted as part of the accreditation process as in itself it limits the practice's ability to share information across providers and ensure the consumer can easily access their own health information.

- 1.24 – we have some concern about how practices would self-determine that Aboriginal and Torres Strait Islander patients face the same risk of harm as the general population. Factors such as systemic racism make it difficult for this to be self-determined by a provider and therefore a broad requirement to make services culturally sensitive should apply.

## *Other issues*

In addition to the issues raised above, the following issues were identified by consumers as part of CHF's consultation process.

Workforce resource levels and staff-patient ratios are factors that can impact safety and quality outcomes for patients. While it is beyond the scope of the NSQPH Standards to specify required staffing levels for every profession or in every circumstance, a broad recognition of the need for appropriate staffing levels should be included in the Standards.

Transport is another issue consistently raised with CHF as a key barrier to accessing health care, particularly in rural and remote areas. While it is not the responsibility of health services to provide transport options, health services should consider whether the consumer has a way to get safely to and from appointments and assist where possible (noting this would likely require additional resources and coordination with other services or parts of government). The use of home visits and outreach services is also an important part of maintaining care for isolated consumers and can minimise 'loss of follow up'. Transport and outreach should be considered as fundamental and necessary parts of care planning.

# Conclusion

We thank the ACSQHC for the opportunity to provide input to this important consultation on the NSQPH Standards. CHF is committed to supporting safe, high quality, timely healthcare for all Australians, supported by the best health information and systems.

We know that health systems with a strong primary health care focus are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes. Effective, integrated and comprehensive primary health care which is consumer-centred and takes a whole-of-person approach is critical to better meeting the needs of individuals, families and communities.

We also know that primary health care in Australia is facing a range of challenges, including the growing burden of chronic disease, an ageing population, adverse funding incentives to achieve volumes of services rather than better outcomes, workforce challenges, and digital innovation. We support the development of the NSQPH Standards to continue to strengthen Australia's primary health care system, supporting services to cope with these challenges.

We are happy to be contacted to clarify or further discuss any of the issues raised in this submission and look forward to continuing to be involved in this project.