

Review of general practice accreditation arrangements

Consultation Paper

11 August 2021

mpconsulting ™

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1. Purpose of this Consultation Paper

Purpose

mpconsulting has been engaged to undertake an independent and comprehensive review of general practice accreditation arrangements (the Review). The Review is examining current arrangements for accreditation of general practices under the National General Practice Accreditation Scheme (the NGPA Scheme) and the various training accreditation frameworks (to the extent these intersect with the NGPA Scheme). The focus of the Review is understanding the barriers and incentives for general practices participating in accreditation and areas for improvement.

To inform the Review, we are seeking stakeholder views on the general practice accreditation arrangements, including:

- the extent to which the NGPA Scheme supports quality, safety and continuous improvement in general practice
- the strengths and limitations of the NGPA Scheme, including the barriers and incentives to participation by general practices and challenges for accrediting agencies
- areas for improvement.

This Consultation Paper is split into:

- general practice accreditation (under the NGPA Scheme)
 - [Chapter 3](#) provides background on these arrangements
 - [Chapter 4](#) provides an overview of some of the key issues relating to general practice accreditation identified for stakeholder consideration
- training accreditation (specifically in relation to the accreditation of training posts for specialist medical training through the Australian General Practice Training (AGPT) Program)
 - [Chapter 5](#) provides background on these arrangements
 - [Chapter 6](#) provides an overview of some of the key issues relating to training accreditation identified for stakeholder consideration.

The Consultation Paper has been informed by research and preliminary engagement with a number of stakeholders. It has been developed to provide stakeholders with background information about the current accreditation arrangements and to highlight some of the issues that have been raised by stakeholders to-date, noting that stakeholders have different perspectives and experiences of the accreditation arrangements.

The Review is seeking to engage with a diverse range of stakeholders and invites submissions from all stakeholders.

How to make a submission

Making a submission

Stakeholders are invited to provide a submission to the Review. Stakeholders may choose to address some or all of the questions in the Consultation Paper or may wish to raise other issues relevant to the Review.

To assist stakeholders to provide feedback, a survey has been developed and is available through the Department of Health's [Consultation Hub](#).

Survey responses and submissions must be received no later than **midnight 8 September 2021**.

Any information provided will help inform recommendations to the Department about how to improve the accreditation of general practices.

Thank you for your interest and we look forward to receiving your submission.

Participating in a Forum

mpconsulting will also be holding virtual forums to seek stakeholder views on specific topics as follows:

Forum	Key issue to be explored	Time and date
1. Access	How the accreditation process might be adapted to different general practice settings and types	10am – 12pm, Monday 30 August 2021
2. Quality and safety	How general practices might be better supported to embed quality and safety processes (as part of the accreditation process and during their period of accreditation)	2pm – 4pm, Monday 30 August 2021
3. Cost	How the costs of accreditation might be determined to ensure equitable access to accreditation for all general practices	10am – 12pm, Wednesday 1 September 2021
4. Training accreditation	Intersections between general practice accreditation and training accreditation (with a focus on the AGPT Program) and areas for improvement	2pm – 4pm, Wednesday 1 September 2021

We ask stakeholders interested in participating in one or more of the above forums to submit their expression of interest to ngpasreview@mpconsulting.com.au before **19 August 2021**, including:

- full name
- organisation (where applicable)
- the stakeholder group you represent – i.e. general practice owner, manager or GP; accrediting agency or a surveyor; peak body; patient; government; other (please describe)
- the session(s) you would most like to participate in.

Note: If there is significant demand, additional forums may be scheduled.

2. About the Review

Purpose of the Review

The key questions for the Review are:

1. Are the current general practice accreditation arrangements under the NGPA Scheme effective for general practices and accrediting agencies to encourage both new and existing practices to continue to seek accreditation and support a competitive market for accreditation agencies whilst still maintaining the robustness and effectiveness of assessment processes?
2. What is the feasibility of combining general practice accreditation and training accreditation to streamline, reduce overheads and reduce the administrative burden on practices considered from both the perspective of the practice, its teaching staff, its learners and the educational institutions?

Key considerations that will enable us to answer these questions include:

- the primary purpose, and intended outcomes, of accrediting general practices
- the impact (or possible impacts) of general practice accreditation
- motivations and incentives for, and barriers to, accreditation for general practices
- incentives, barriers and market pressures for accrediting agencies
- contextual differences for accreditation of general practices located in rural and remote locations (and how the accreditation process might allow for these) and for Aboriginal Community Controlled Health Organisations
- the role of the Joint Accreditation Scheme of Australia and New Zealand (JAS-ANZ) and the International Society for Quality in Healthcare (ISQua)
- overlaps between general practice and training accreditation, including options for combining or streamlining these processes
- opportunities for streamlining and improving the general practice accreditation process to address barriers and promote uptake of accreditation.

Review process

The stages and timeframes for the Review are as follows.

Stage	Key activities	Timeframe
Research and preliminary engagement	<ul style="list-style-type: none"> • Research • Initial engagement with some key stakeholders • Identification and collection of data 	Late June to August 2021
Consultation	<ul style="list-style-type: none"> • Publication of consultation paper • Online surveys • Virtual forums • Report on outcomes of consultation 	August to September 2021

Stage	Key activities	Timeframe
Reporting	<ul style="list-style-type: none"><li data-bbox="501 255 1158 320">• Presentation of final report and recommendations to Government	October 2021

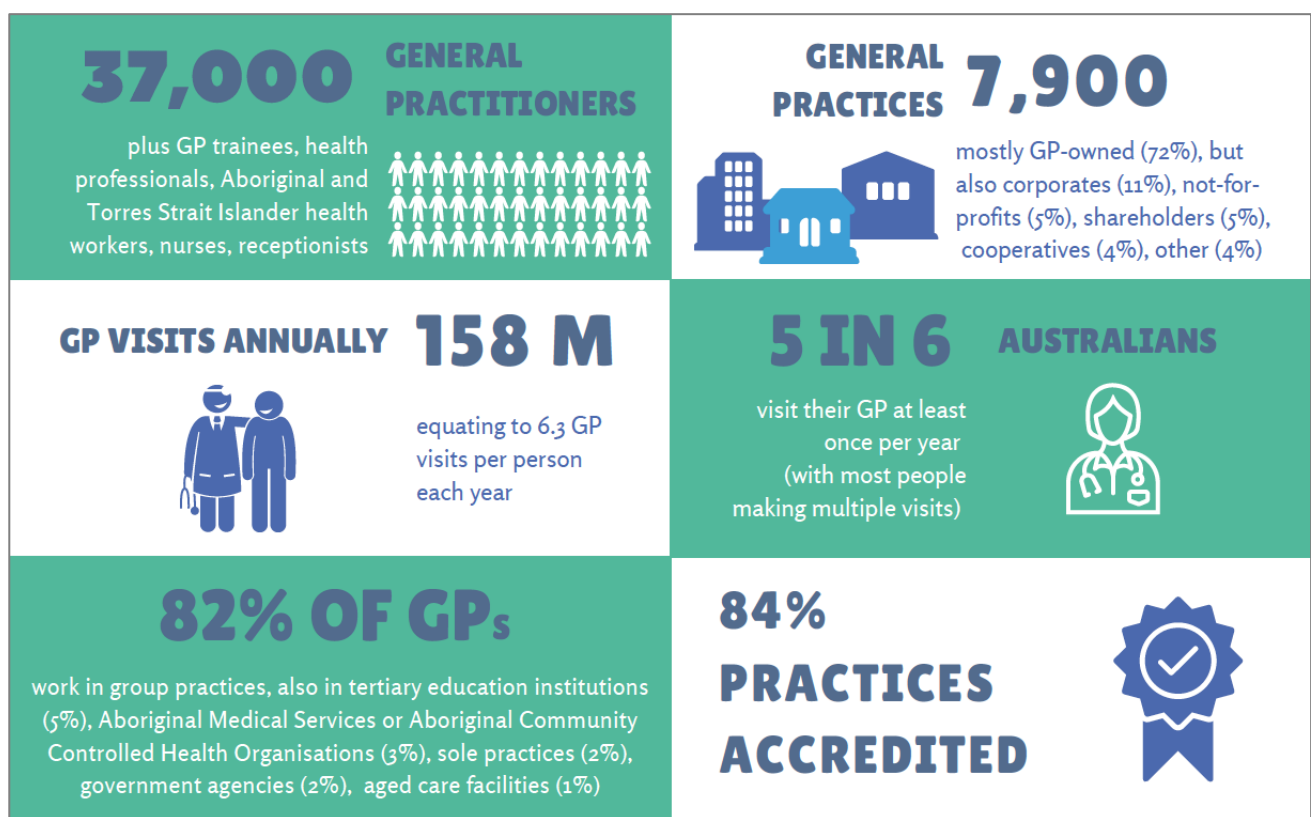
3. General practice accreditation – background

Overview of general practice in Australia

Key demographics

General practitioners (GPs) treat a broad range of health issues and are a critical component of Australia’s primary healthcare system. Primary health services are often the first point of contact a person has with the health system and account for a significant proportion of health care services in Australia.

Diagram 1: General practice key statistics¹



Australians access general practice more than any other part of the health system, with more than 80% of Australians visiting their GP at least once a year. Use of general practice is increasing, with over 158 million GP attendances nationally (6.3 per person) in 2018-19, up from 113 million GP attendances nationally (5.3 per person) in 2008-09.²

¹ Data is drawn from: Australian Institute of Health and Welfare, July 2020, [Australia’s health in 2020 – Primary health care](#); EY Sweeney, May 2020, *RACGP GP Survey* cited in the Royal Australian College of General Practitioners (RACGP), November 2020, *Health of the Nation 2020*; Medicare Benefits Schedule (MBS) data.

Note: Not all of the 7,900 practices are currently eligible to be accredited (based on the RACGP’s core criteria). As such, the proportion of accredited general practices (of those that are eligible to be accredited) may be higher than 84%.

² Australian Institute of Health and Welfare, July 2020, [Australia’s health in 2020 – Primary health care](#).

GPs are located right across Australia, with most located in major cities. GPs are less accessible in remote locations, with approximately 121 FTE GPs per 100,000 people in major cities, 115 in inner regional areas, 101 in outer-regional areas, 83 in remote areas and 69 in very remote areas.³

Service offerings

GPs provide a broad range of services to patients, including preventative care and the diagnosis and treatment of illness and injury, through direct service provision and/or referral to acute (hospital) or other healthcare services.

The service delivery model and nature of services provided by general practices are diverse. For example:

- some practices offer outreach services to other locations
- many practices offer telehealth services, with some practices providing services purely through telehealth⁴
- some practices provide services into residential aged care facilities, public and private hospitals and community healthcare services
- GP proceduralists, particularly in rural and remote practices, often offer a wide range of services including anaesthetics, obstetric and surgical services
- some practices also provide allied health services, dental services, diagnostic imaging, pathology services (including for example, practices participating in the Department's recently concluded Health Care Homes program trial)
- some practices specialise in provision of care to particular patient cohorts – for example, Aboriginal Medical Services and practices specialising in women's health.

Funding and regulation

General practices derive their income largely from fee for service payments from patients (who are then reimbursed via the MBS) or directly via the MBS and from the Department of Veterans' Affairs (DVA). Some funding is also provided:

- to influence the supply, regional distribution and nature/quality of general practice services, through initiatives such as the Practice Incentives Program (PIP) and through Primary Health Networks (PHNs)
- to incentivise the engagement of medical students, junior doctors and GP trainees (such as supervisor allowances and contributions towards clinical placements)
- by State and Territory governments to support, for example, the employment of GPs in rural and remote areas
- from insurance schemes and patient contributions.⁵

Governments also set requirements that must be met by general practices and GPs, either as a condition of funding or by law. For example:

³ EY Sweeney, May 2020, *RACGP GP Survey* cited in the Royal Australian College of General Practitioners (RACGP), November 2020, [Health of the Nation 2020](#), p. 52.

⁴ It is a requirement of MBS billing by telehealth that a face-to-face consultation is provided if clinically indicated.

⁵ Productivity Commission, January 2021, [Report on government services 2020](#), Part E, Section 10.

- health practitioners (such as GPs and allied health professionals) must be registered with Australian Health Practitioner Regulation Agency (Ahpra) and meet requirements relating to their criminal history, conduct, English language skills, recency of practice, continuing professional development (CPD), professional indemnity insurance, etc.
- the Department's Professional Services Review (PSR) Scheme regulates practices in connection with claiming Medicare services and investigates inappropriate claiming
- some government funded programs require general practices providing certain services or specialising in certain areas (such as drug and alcohol and mental health) to meet requirements to access funding.

The focus of the Review is general practice accreditation, which is an eligibility requirement for some Commonwealth payments to both practices and GPs.

History of general practice accreditation

Accreditation of general practices commenced in 1992, stemming from *The Future of General Practices: A Strategy for the Nineties and Beyond*. Accreditation was introduced as a formal, peer-driven external process, with a focus on 'continuing quality improvement'⁶.

The Department funded the RACGP to establish the first edition of the Standards, which have evolved over time and are now the [RACGP Standards for general practice](#) (the Standards). The Department also funded the establishment of a not-for-profit accrediting agency to undertake assessment of general practices against the Standards and make decisions on accreditation.

Accreditation was introduced as an eligibility criterion for the PIP in 1999. Following an audit of the PIP in 2010, the Australian National Audit Office (ANAO) recommended that the Department build capability to understand the effectiveness of the PIP (including through the development of an evaluation strategy and implementation of annual public reporting) and develop a mechanism to inform itself of the quality of general practice accreditation.⁷

In line with these recommendations, the Australian Commission on Safety and Quality in Healthcare (the Commission) partnered with the RACGP to develop a model accreditation scheme for general practices in Australia. This model evolved over years of consultation and became the NGPA Scheme, which commenced on 1 January 2017.

Overview of the NGPA Scheme

Key features of the NGPA Scheme

World-wide, accreditation schemes share similar features including:

- a governance or stewardship function

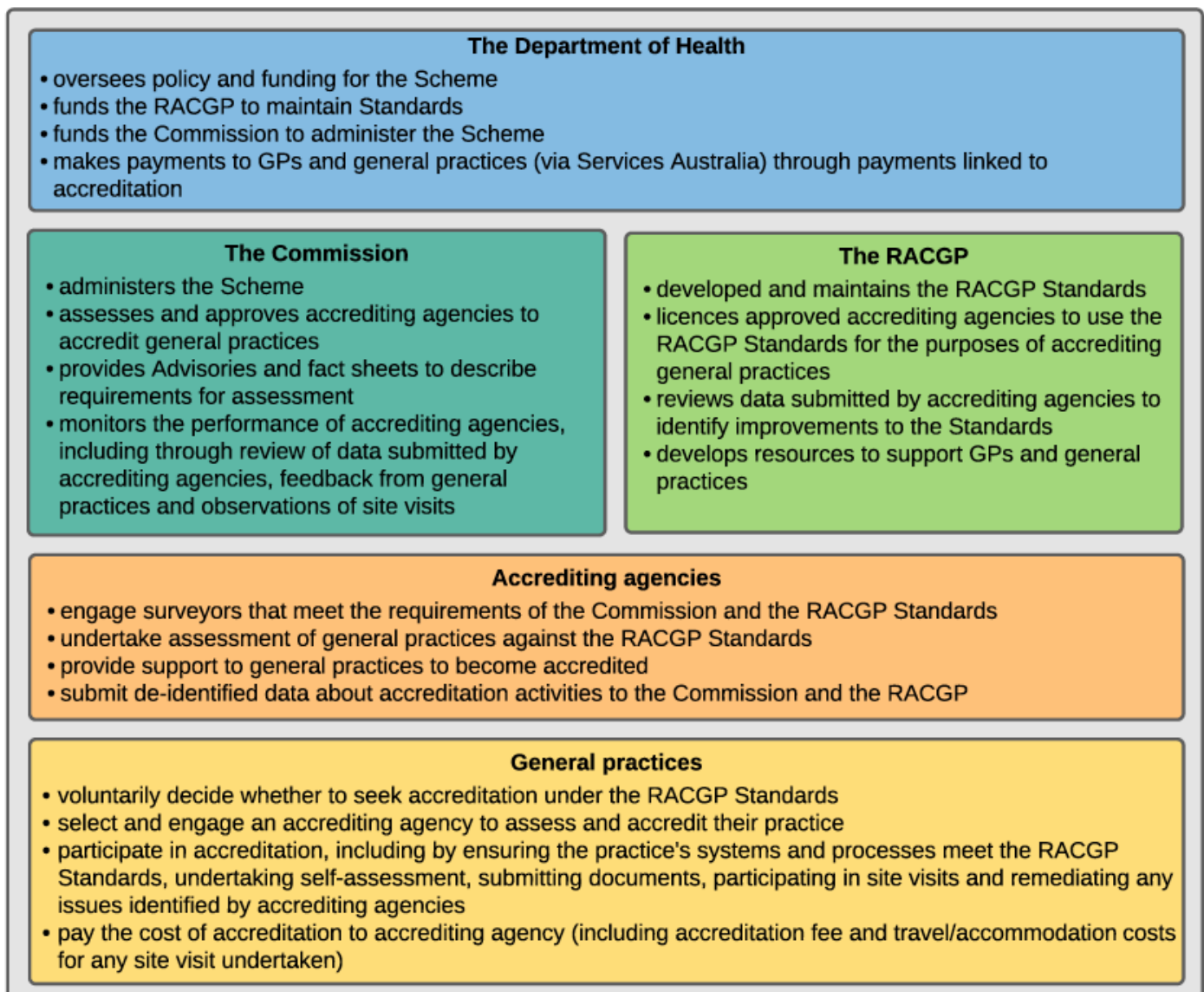
⁶ General Practice Consultative Committee, 1992, *The Future of General Practice: A strategy for the Nineties and beyond*, p. 6.

⁷ Australian National Audit Office (ANAO), September 2010, [Audit Report No.5 2010–11 Performance Audit – Practice Incentives Program for the Department of Health and Ageing, and Medicare Australia](#), p. 27.

- a standards-setting process
- a process of independent assessment of performance against those standards
- a remediation or improvement process following the assessment
- promotion of continuous quality improvement.⁸

The NGPA Scheme also shares these features.

Diagram 2: Overview of NGPA Scheme



Purpose

Most health accreditation schemes focus on safety, quality and continuous improvement. This is also the case for the NGPA Scheme.

The Standards describe their purpose as ‘protecting patients from harm by improving the quality and safety of health services. The Standards also support general practices in identifying and

⁸ Australian Council on Healthcare Standards (ACHS), January 2018, [What is Accreditation?](#).

addressing any gaps in their systems and processes'.⁹ Likewise, the Commission states that general practice accreditation is 'designed to review the systems for managing risks and to improve the quality of patient care'.¹⁰

Governance

There are several parties involved in the governance of the NGPA Scheme:

- the Department:
 - provides funding to the RACGP to develop and maintain the Standards
 - provides funding to the Commission to administer the NGPA Scheme
 - makes payments to general practices and GPs (via Services Australia) through a range of payments linked to accreditation.
- the Commission – in collaboration with the General Practice Accreditation Coordinating Committee (the GPACC)¹¹ – approves and oversees the performance of accrediting agencies and works with the RACGP to develop advisories regarding interpretation of the Standards
- the RACGP developed and maintains the Standards and licences accrediting agencies to use the Standards for the purposes of accrediting general practices. As a membership body, the RACGP also advocates for GPs and develops resources to support GPs and general practices
- accrediting agencies provide guidance and resources to support general practices to become accredited, assess general practices against the Standards, make decisions about accreditation and report on their accreditation activities to the Commission and the RACGP
- a number of other organisations support general practices, including Primary Health Networks (PHNs) and peak bodies, such as the Australian Medical Association (AMA) and the Rural Doctors Association of Australia (RDAA).

Standards-setting

The RACGP developed and maintains the Standards. The Standards have evolved over time and are currently in their fifth edition. The Standards include 124 indicators (including 116 mandatory and eight aspirational indicators) across 23 criteria, covering three modules:

- the core module, which examines matters such as communication and patient participation, rights and needs of patients, practice governance and management, health promotion and preventative care, clinical management of health issues, information management, content of patient health records, education and training of non-clinical staff
- the quality improvement module, which examines matters such as quality improvement, clinical indicators, clinical risk management
- the general practice module, which examines matters such as access to care, comprehensive care, qualifications of clinical team, reducing risk of infection, medical practice, vaccine potency.

The Standards specify that to seek accreditation, a practice must meet three core criteria:

⁹ Royal Australian College of General Practitioners, [Standards for general practice \(5th edn\)](#), p. 1.

¹⁰ Australian Commission on Safety and Quality in Healthcare, [Overview of NGPA Scheme Factsheet](#).

¹¹ The GPACC is an industry-based committee that oversees the Commission's management of the NGPA Scheme and includes members from the Commission, the RACGP, the Australian College of Rural and Remote Medicine, the Australian Primary Health Care Nurses Association, the Australian Association of Practice Management, Allied Health Professions Australia, PHNs and consumers.

- the practice or health service operates within the model of general practice described in the [RACGP definition of the general practice speciality](#), which sets out 10 characteristics that define the speciality of general practice
- GP services are predominantly of a general practice nature
- the general practice is capable of meeting all mandatory indicators in the Standards.

It should be noted that the RACGP is currently reviewing the above definition of general practice.

Assessment

There are currently five accrediting agencies approved by the Commission to undertake assessment against the Standards and accredit general practices.

A general practice can select an accrediting agency of their choice and must meet the costs of accreditation as set by each accrediting agency. The accrediting agency works with the general practice to undertake assessment against the Standards, which generally includes a self-assessment by the practice, desktop review and an on-site assessment.

Remediation

Following the on-site assessment, the accrediting agency notifies the general practice of the outcome of the initial assessment, including specifying all matters that require remediation.¹² Where a general practice has not met all mandatory indicators, it has up to 65 business days to complete remediation. Following this, the accrediting agency undertakes further assessment (usually conducted through a desktop review) and produces a final report describing the outcomes of the assessment.¹³

General practices that have demonstrated they meet all the requirements of the Standards are accredited. Accreditation is for a period of three years.

Continuous quality improvement

It is expected that general practices maintain conformance with the Standards throughout the period of accreditation and engage in continuous quality improvement.

The Standards state that the purpose of quality improvement is for general practices to 'identify opportunities to make changes that will improve patient safety and care. Quality improvement can be achieved in a number of ways, one of which is the regular review of [a] practice's structures, systems and clinical care. Improvement needs to be based on the practice's own information and data, which can be collected in a variety of ways, including feedback from patients and the practice's team, and audits of clinical data. All members of the practice team need to have opportunities to contribute to the practice's quality improvement activities'¹⁴.

¹² Australian Commission on Safety and Quality in Healthcare, [Policy – Approval under the National General Practice Accreditation \(NGPA\) Scheme to conduct accreditation of general practices using the Royal Australian College of General Practitioners \(RACGP\) Standards for general practices](#), p. 26, clause 6.8.

¹³ Australian Commission on Safety and Quality in Healthcare, [Overview of NGPA Scheme Factsheet](#).

¹⁴ Royal Australian College of General Practitioners, [Standards for general practice \(5th edn\)](#), p. 88.

Requirement to be accredited

While the NGPA Scheme is a voluntary accreditation scheme, accreditation is an eligibility criterion to access a number of Commonwealth programs, including:

- the PIP – The PIP comprises eight incentive payments under three payment streams – quality stream, capacity stream and rural support stream. Some of these payments are made to the general practice, some to the individual GPs and some represent a rural loading for practices where the primary practice location is outside a capital city or other major metropolitan centre. MBS data shows that over the 2020-21 financial year, a total of \$443 million was paid in PIP payments across 6,533 general practices, indicating that on average each practice received \$68,000 in PIP payments (noting there is significant variation in payment amounts depending on the practice size and number of incentives the practice is participating in).¹⁵
- the Workforce Incentive Program (WIP) Practice Stream – The WIP provides targeted financial incentives to encourage doctors to deliver services in rural and remote areas through the GP Stream and to employ practice nurses and allied health professionals through the practice stream. Over \$387 million is paid to general practices and GPs through the WIP annually.¹⁶

Number of accredited practices

Based on data held by the Department, approximately 6,600 general practices are accredited (84%¹⁷).

There were 1,976 general practices accredited in 2019-20¹⁸. Just over two-thirds of all general practices assessed were in metropolitan areas (69%), and more than half were in New South Wales and Victoria (58%).¹⁹

Since the inception of accreditation in general practice and the linking of accreditation to payments, there has been an increase in the number of accredited general practices, from 4,783 (67%) as at June 2011²⁰ to 6,600 (84%) as at June 2021²¹.

Impact of general practice accreditation

Benefits of accreditation

The benefits of accreditation are widely and consistently reported in literature, both Australian and international. Key benefits include:

¹⁵ Data provided by the Department of Health.

¹⁶ For the period of 2019-20, see Services Australia, [Annual Report 2019-20](#), p. 30.

¹⁷ It is expected that not all of the 7,900 practices are eligible to be accredited (based on the RACGP's core criteria). As such, the proportion of general practices that are eligible to be accredited may be higher than 84%.

¹⁸ This includes Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations.

¹⁹ Australian Commission on Safety and Quality in Health Care, September 2020, [Annual Report 2019-20](#), p. 29.

²⁰ Productivity Commission, 2019, [Report on Government Services – Primary and community health, Part E, Chapter 10](#), table 10A.50.

²¹ Based on data provided by the Department of Health.

- accreditation can support general practices to set up systems and processes to support the effective operation and management of the practice
- accreditation can provide an opportunity for practices to learn, continuously improve and benchmark their performance
- improved ability to identify and manage risk including to patient safety
- participation in the accreditation process can be good for organisational culture, engagement, and job satisfaction
- accreditation can provide assurance to patients that the general practice delivers safe and quality care.

General practice surveys undertaken by one of the accrediting agencies also suggest that:

- 93% of respondents agree or strongly agree that the process of accreditation promotes quality improvement
- 90% of respondents agree or strongly agree that accreditation assists the practice to formulate strategies for improving its service.²²

It is more challenging to quantify the impact of general practice accreditation in Australia. This is due to:

- challenges disentangling the effect of accreditation from other quality improvement initiatives
- limited baseline data about safety and quality in general practice
- the relatively short period of time during which the current accreditation process has been in place (noting that the NGPA Scheme commenced on 1 January 2017).

Each general practice will have a different experience of accreditation and the impacts on that practice, its staff and its patients.

Consultation questions

1. What are the benefits of accreditation to general practices, GPs and other staff and patients?

Limitations of, and barriers to, accreditation

Not all practices have had a positive experience of accreditation. Some GPs, practice owners, and/or managers and others consulted as part of this Review:

- reported the current system of accreditation did not drive quality and safety and was instead a 'tick and flick exercise', primarily for the purposes of accessing PIP payments
- noted the costs to the practice (in time and resources) can outweigh the perceived benefits
- questioned the benefits of accreditation outside the hospital setting
- felt that accreditation could erode professional autonomy (by requiring GPs to adjust their practice to meet the Standards)
- described the benefits of accreditation diminishing over time

²² Survey data provided by AGPAL for 2,680 respondents.

- noted that they did not have the time to focus on improvements to practice systems and processes, noting that anything that took away from time with patients ultimately impacted the financial viability of practices
- felt there were inadequate supports for general practices struggling to meet some of the standards or otherwise seeking to improve in key areas
- expressed a lack of confidence in some aspects of the accreditation process. For example, some stakeholders noted:
 - perceived conflicts of interest impacting the governance of the NGPA Scheme and therefore confidence in it (discussed further under [governance](#))
 - inconsistency in assessment within, and between, accrediting agencies
 - concerns about the Standards (being too prescriptive, too focused on business practice rather than patient safety and quality or not relevant in different contexts)
 - the absence of surveillance or monitoring, resulting in variable/unsustained conformance during the accreditation period.

Each of the factors described can act as a barrier to practices genuinely engaging with accreditation. There may also be other factors relating to the location or profile of the general practice that present a barrier to participation in accreditation. For example, while there is limited data about unaccredited practices, anecdotally, unaccredited practices are more likely to be: solo and small general practices; located in regional, rural and remote Australia; or operated by a GP who is from a non-English speaking background or nearing retirement.

Consultation questions

2. What are the barriers to accreditation and to the achievement of the overarching outcomes sought from accreditation (e.g. continuously improving quality and safety)?

A focus for the Review is understanding the benefits of accreditation, barriers to participation and the features of the current NGPA Scheme that may be impeding the achievement of the outcomes sought.

4. General practice accreditation – key issues for consideration

Context

This Chapter explores some of the issues that have been identified through research, data analysis and early consultation with stakeholders.

Issues have been described in relation to each of the key elements of the accreditation scheme:

- governance
- the Standards
- assessment against the Standards, including:
 - requirements for accrediting agencies and surveyors
 - the assessment approach
 - non-conformance and remediation following assessment
 - cost of accreditation
- promotion of continuous quality improvement.²³

In considering the issues (and identifying options to address any shortcomings in the current system or areas for improvement) the Review acknowledges:

- the critical role that general practices play in the delivery of primary health care
- the general practice context. We are mindful that:
 - general practice is very different from hospitals and acute care, and most practices do not have individuals or teams dedicated to implementing and maintaining organisational quality and safety systems and driving continuous improvement
 - general practices are diverse in terms of size, structure, the business models employed, the communities they serve and how they engage with other health services
- broader health policy and funding issues that necessarily intersect with accreditation, including the proposed [Primary Health Care 10-Year Plan](#) currently being developed
- while all stakeholders share a common interest in ensuring provision of safe, quality care, stakeholders have different views around how best to achieve this, including the role that accreditation should play and any changes that may be desirable. The focus for the Review will be identifying options that:
 - continue to focus on improving quality and safety
 - provide clarity in terms of the purpose of accreditation and governance of the scheme
 - minimise unnecessary regulatory and administrative burden
 - ensure equity of access
 - build confidence in accreditation
 - support general practices to drive continuous improvement.

²³ The Australian Council on Healthcare Standards, January 2018 [What is Accreditation?](#).

Governance

Effective accreditation schemes depend on strong governance. Good governance is about:

- clarity of purpose and outcomes sought
- clarity of roles and responsibilities between different players in the system – in this case, clarity of roles and responsibilities between the Department, the Commission, the RACGP and accrediting agencies
- transparency, along with the avoidance (or effective management) of conflicts of interest that can undermine confidence in the scheme
- stakeholder engagement to ensure that the standards and the assessment processes are fit for purpose and adapted to the context
- continuously improving the scheme.

Good governance ensures stakeholders have confidence that the arrangements will deliver the outcomes sought.

- **Clarity of purpose and outcomes sought**
 - The purpose of the NGPA Scheme (and the outcomes sought) are clearly articulated in the Standards themselves, along with communications from the RACGP, the Commission and accrediting agencies.
 - However, some stakeholders have quite different notions of the purpose of the Scheme and the outcomes sought. Some stakeholders described the Scheme as being about peer review, whereas others felt it should be an independent assessment of performance against the Standards. Some saw it as a ‘pathway to PIP’ (boxes that need to be ticked to access funding) and others focused more strongly on the importance of quality systems.
- **Clarity of roles and responsibilities (including transparency and avoidance of conflicts)**
 - Many stakeholders commented on the complexity of the governance arrangements, the lack of clarity regarding relative responsibilities of different bodies and duplication of effort.
 - For example:
 - The RACGP has responsibility for the development and maintenance of the Standards, and for the development of [guidance and resources](#) to support general practices in understanding the requirements of the Standards. The Commission produces [Advisories](#) and fact sheets to support assessment against the Standards.
 - While the Commission is responsible for assessing, approving, setting expectations for and monitoring the performance of accrediting agencies (in line with the Commission’s policy), the RACGP also outlines expectations of accrediting agencies within the Standards²⁴ themselves and requires accrediting agencies to demonstrate certain matters to the RACGP directly.
 - Accrediting agencies are required to demonstrate their capability to both the Commission and the RACGP and to report detailed information about accreditation activities to both.
 - In terms of support for general practices to meet the requirements, the Commission, the RACGP and accrediting agencies all play a role. Other peak bodies and PHNs also provide support to practices, with differences across geographical areas.

²⁴ Royal Australian College of General Practitioners, [Standards for general practice \(5th edn\)](#), pp. 4-7.

- Other stakeholders focused on perceived conflicts of interest noting that:
 - o some accrediting agencies both support general practices to meet the Standards (including by providing resources, training, templates and standardised policies and procedures) and assess the performance of general practices against the Standards
 - o the RACGP develops and maintains the Standards (with a focus on driving safety and quality care for patients) but also plays a role in training and educating GPs and advocating for GPs as a membership body.
- **Stakeholder engagement, with a focus on learning and continuous improvement**
 - Deep stakeholder engagement is critical to any accreditation scheme – it is about partnerships, collaboration, seeking feedback from a wide range of stakeholders and using this to inform adjustments to governance, standards and the accreditation processes. It is also about using data to understand the impact of the scheme and to inform policy and funding initiatives, as well as learning from other systems.
 - Extensive stakeholder engagement has informed the development of the Standards and the NGPA Scheme more broadly. However:
 - o until recently, the Commission has been unable to collect data that could be used to inform improvements to the NGPA Scheme
 - o the Commission does not have oversight of which general practices are accredited and thus has limited ability to directly interact with practices to seek feedback on the Scheme (discussed further under [data and transparency](#))
 - o stakeholders have different views about the extent to which the NGPA Scheme should be ‘profession led’ or ‘profession informed’ (which influences expectations around partnership and consultation)
 - o stakeholders have different views about the extent to which learnings can be drawn from the acute or other sectors
 - o some of the custodians of data relating to the NGPA Scheme can be reluctant to share information, including due to commercial sensitivities, competitive markets, perceptions of conflict of interest, concern regarding litigation or the potential for performance information to reflect negatively on the sector or a part of the sector.

Consultation questions

3. What are the strengths and limitations of the current governance arrangements for the NGPA Scheme?
4. How could the governance be improved, including to ensure clarity of purpose, roles and responsibilities and to support continuous improvement and drive confidence in the NGPA Scheme?

The Standards

Most accreditation schemes have at their core a set of standards that include a number of criteria or indicators against which entities demonstrate their performance.

Ideally, standards should be:

- outcomes focused (enabling organisations to demonstrate compliance or conformance in different ways and as relevant to their patients, the services they offer and the environment in which they operate)
- fit for purpose and meaningful (i.e. well adapted to context)
- measurable
- well directed towards the outcome sought.

Where there are intersecting standards (across different accreditation schemes that may be relevant to a single general practice) there should also ideally be a degree of coherence across the standards such that the practice is not required to demonstrate outcomes fundamentally differently across different schemes.

The Standards for general practices were developed by the RACGP in consultation with GPs, practice managers, nurses, consumers, technical experts and others. Stakeholders have noted the improvements that have been made to the Standards over time and the value of the fifth edition of the Standards being modular in structure (including a core module, quality improvement module and general practice module) enabling modules to be adapted to different healthcare settings.

While the Review will not assess the Standards in detail, our focus will be on understanding whether the Standards (which are a central part of the accreditation regime) may themselves be acting as either an incentive or barrier to accreditation and to the achievement of the overall outcomes sought (safety, quality and continuous improvement).

Some of the issues being considered as part of the Review include:

- **scope and focus of the Standards**
 - Based on consultations undertaken to date, some stakeholders have suggested that:
 - elements of the Standards extend beyond quality and safety considerations and reach more generally into business management, such that the Standards could unreasonably impose on the professional autonomy of GPs and practice owners. One example provided was the requirement relating to criteria C3.1 which provides that ‘You must plan and set business goals’
 - with 124 indicators across 23 criteria included in the Standards, some stakeholders have suggested there are too many indicators (creating burden in terms of demonstrating conformance) or that the indicators are too prescriptive (describing how practices should meet the criteria rather than the outcomes sought)
 - certain indicators are more challenging to meet in rural or remote environments. For example, indicator C6.1A requires the practice to use a minimum of three approved patient identifiers each time a patient attends or calls the practice. While noting the importance of proper patient identification, some stakeholders have reported that such identification may not be necessary where patients are well known to staff
 - some indicators may drive practices to generate certain documents/evidence purely for the purpose of the accreditation assessment, rather than driving improvements to quality and safety. For example, C2.1E requires the clinical team to ‘document any ethical dilemmas that have been considered, and the outcome or solution’. Some practices reported that, as suggested in the Standards, they generate notices regarding

ethical dilemmas to display in the waiting room purely for the purposes of the assessment.

- **fit for purpose into the future (noting the changing primary health landscape)**
 - General practice services are increasingly being delivered through different service models and settings. For example, as a result of the COVID-19 pandemic, general practice services are now commonly delivered by Telehealth. GPs also practice in aged care services, community health services, in prisons, etc.
 - The RACGP has developed a number of additional, related standards to account for some of these different service delivery settings (e.g. [Standards for after-hours and medical deputising services](#), [Standards for health services in Australia immigration detention centres](#), [Standards for health services in Australian prisons](#)).
 - Some stakeholders have suggested that a single set of standards should be able to be applied regardless of the practice setting/service delivery model (noting that these will continue to evolve with technology and the broader health system) with specific guidance and tools developed as needed.

- **intersection with other standards including the Commission’s primary and community healthcare standards**
 - The Commission has recently developed the [National Safety and Quality Primary and Community Healthcare Standards](#) (the Primary and Community Healthcare Standards Standards) for services that deliver healthcare in a primary and/or community setting.
 - Primary and community healthcare services will be able to become accredited to the Primary and Community Healthcare Standards under the [Australian Health Service Safety and Quality Accreditation](#) (AHSSQA) Scheme, which will provide for the national coordination of accreditation processes.
 - The Standards note that, ‘where profession-specific standards already exist, these should align with the Primary and Community Healthcare Standards to ensure a nationally consistent approach to safety and quality improvements across the primary and community healthcare sector’.²⁵
 - While the Primary and Community Healthcare Standards cover similar matters to the RACGP Standards for general practices, the structure of, and requirements under, the two sets of standards are quite different.
 - Stakeholders have:
 - queried whether general practices could/should become accredited under the Primary and Community Healthcare Standards and whether this could present an alternative pathway to general practice accreditation (including for the purposes of accessing PIP payments)
 - expressed concern about another set of standards and the potential for another process that risks duplication and confusion regarding expectations of practices.
 - Stakeholders also identified that many general practices are subject to a range of different standards and assessment processes based on the nature of their practice and whether they are also a training post. While it is acknowledged that different standards and assessment processes have different foci, there may be opportunity to better enable practices to utilise the same evidence to demonstrate conformance with the different standards (particularly if

²⁵ Australian Commission on Safety and Quality in Healthcare, June 2021, [National Safety and Quality Primary and Community Healthcare Standards](#), p.4.

the standards are more outcomes focused) or to better coordinate assessments (reducing costs associated with multiple site visits). This is discussed further under [intersection with other accreditation schemes](#).

Consultation questions

5. What are the strengths and limitations of the current Standards for general practices?
6. How could the Standards for general practices be improved, particularly to ensure they are practical and meaningful for all general practices, remain relevant into the future and do not impose unnecessary regulatory burden on general practices?

Assessment against the Standards

Requirements for accrediting agencies

There are currently five accrediting agencies approved to conduct assessments under the NGPA Scheme, although not all these agencies are currently participating in the market (i.e. conducting assessments).

Once approved, both the Commission and the RACGP place ongoing obligations on accrediting agencies. Some of these obligations (imposed through agreements with the RACGP or as part of approval by the Commission) include:

- **the requirement for accrediting agencies to be accredited by a recognised accreditation body – JASANZ, ISQua or another internationally recognised body.**
 - This is in line with arrangements under the AHSSQA Scheme and a number of other Commonwealth and State-based accreditation schemes. Some stakeholders have suggested that:
 - different accreditation bodies have different expectations of accrediting agencies and may apply different levels of rigour in their assessment of accrediting agencies
 - there are significantly different costs for accrediting agencies in maintaining compliance with their accreditation requirements (such that this creates market distortions).
- **surveyor workforce specifications**
 - This includes specifying that:
 - two or more surveyors should undertake assessment, including at least one GP surveyor
 - GP surveyors must (among other things): have at least five years' FTE experience as a vocationally registered GP; and be working at least two sessions a week in face-to-face patient contact in an accredited general practice (or have done so within the last two years)
 - non-GP surveyors (among other things): can be an appropriately qualified nurse, practice manager, allied health professional or Aboriginal and Torres Strait Islander health worker or health practitioner; must have at least five years' FTE experience; and

must be working at least 16 hours a week in an accredited general practice (or have done so within the last two years).²⁶

- While this aims to ensure that surveyors have adequate understanding of the context within which general practices operate, these requirements can limit the ability for accreditation agencies to recruit surveyors who may have much broader experience of accreditation (including in other sectors), may mean that individuals are more likely to bring their own perspective/bias as a GP and may limit the pool of people from whom accrediting agencies can recruit.
- **requirements relating to performance**
 - This includes requirements relating to preventing bias, managing conflicts of interest, ethical and lawful conduct and ensuring that accrediting agencies have assessment methodologies and processes that support independent assessment.
- **requirements relating to reporting and submission of data**
 - Accrediting agencies are required to report some data annually to the Commission and to comply with the Commission’s [data collection and reporting framework](#), which requires monthly reporting (see [data and transparency](#)).
- **requirements to participate in annual performance meetings as well as various working groups.**
 - The Commission monitors the performance and compliance of accrediting agencies with the requirements of the NGPA Scheme by receiving data, feedback from general practices and stakeholders and observation of agencies’ assessment practices. While the Commission has the power to undertake observational audits of assessment site visits, the Commission only undertook one such audit in 2019²⁷ and none in 2020 (due to COVID-19).

Issues for the Review include:

- whether there is any need (or opportunity) to adjust or strengthen the oversight of accrediting agencies including to ensure consistency of assessment, management of potential conflicts and to continue to build confidence in the NGPA Scheme and the independence and quality of assessment
- opportunities to encourage greater feedback from general practices to accrediting agencies, the Commission and/or RACGP and to use this feedback to drive improvements
- whether there are any requirements that impose unnecessary burden such that they may increase costs to accrediting agencies which may be passed on to general practices
- whether there are opportunities to adjust the requirements on the surveyor workforce including to ensure that surveyors understand both the general practice context and best practice assessment methodologies (common across accreditation schemes).

²⁶ Royal Australian College of General Practitioners, [Standards for general practice \(5th edn\)](#), pp. 5-7.

²⁷ This was attributed, in part, to challenges obtaining consent from general practices, which is being addressed moving forward through requiring accrediting agencies to specify in their contracts that general practices must consent to observation of site visits.

Consultation questions

7. What are the strengths and limitations of the requirements for (and oversight of) accrediting agencies?
8. How could the arrangements relating to accrediting agencies (including for surveyors) be improved?

Assessment approach

The assessment process broadly includes a self-assessment completed by the general practice (which highlights the areas where the practice needs to make improvements), may include a desktop review of certain documents and a site visit to the general practice.

While different practices report different experiences of accreditation, four main issues (or opportunities for improvement) have arisen through consultations to date.

- **the depth and focus of assessment**
 - Some stakeholders have reported that the assessment process can be a ‘tick and flick exercise’. While some stakeholders attribute this to the attitude/culture of the general practice being accredited (and whether assessment is seen as a valuable opportunity for the practice to improve its systems and processes or whether it is seen as a compliance burden), others have suggested this is influenced by the Standards and/or the assessment approach, which can tend to focus on documentary evidence of conformance with indicators, as opposed to outcomes.
- **site visits**
 - Site visits – to examine how the practice is conforming with the Standards on the ground – are an important part of any accreditation scheme.
 - The amount of time that surveyors spend on site (and activities conducted on site) necessarily varies based on the size of the practice. However, different stakeholders have variously suggested that:
 - there is significant variation in site visit duration (between surveyors and accrediting agencies) that cannot be accounted for based on the size of the practice
 - site visits are too short to allow adequate sampling of evidence against the Standards, including robust discussions with practice staff
 - site visits are too long, describing the impact of the site visit on the practice’s capacity to see patients during this time.
 - There may also be opportunity to consider the need for site visits in all circumstances, particularly where a general practice is operating through outreach sites visited infrequently by GPs. If there are common systems and processes across the primary site and the outreach sites, virtual visits of outreach sites may be possible (including to reduce costs to remote practices).
- **consistency of assessment**
 - While a level of consistency in assessment approach and outcomes is critical to have confidence in an accreditation process, all accreditation schemes experience challenges in

maintaining consistency between accrediting agencies, between surveyors and across each assessment undertaken.

- The NGPA Scheme utilises several mechanisms to support consistency in accreditation approach and outcomes:
 - o requiring organisations to demonstrate their frameworks and capabilities as part of their application for [approval](#) as an accrediting agency under the NGPA Scheme
 - o setting out a standardised, high-level [assessment process](#) that accrediting agencies must adhere to
 - o monitoring the performance of accrediting agencies, including through requiring regular reporting
 - o providing [Advisories](#) regarding assessment processes.
- However, there may be opportunity to improve consistency of assessment and the robustness of the assessment process. For example, some stakeholders have suggested:
 - o developing a more detailed high-level assessment methodology for application across all accrediting agencies (such as the [PICMoRS Method](#) used under the AHSSQA Scheme)
 - o providing common guidance, resources and training specifically for surveyors (e.g. developed by the Commission and/or the RACGP rather than by individual accrediting agencies)
 - o regularly moderating a sample of assessment reports from each accrediting agency to identify key areas of inconsistency
 - o undertaking more proactive, in-depth data analysis, including to analyse consistency of outcomes across accreditation agencies.
- **patient engagement**
 - Patient engagement is a cornerstone of contemporary health service practice, informing the way that care is delivered and improvements to quality and safety.
 - However, patient feedback can be difficult for practices to elicit, particularly for small practices or where only a limited range of feedback mechanisms are utilised. For example, surveys are not always the most appropriate way to engage patients in a meaningful way (particularly in more marginalised populations). A range of strategies can be used to elicit patient feedback to general practices, accrediting agencies and organisations such as the Commission.
 - An issue for consideration is how the Scheme can drive an increased focus on patient participation while recognising the context within which general practices operate.
- **monitoring and surveillance of conformance**
 - Currently, during the three-year accreditation cycle, general practices usually only interact with their accrediting agency during the assessment period.
 - While the expectation is that general practices continuously review and improve their systems and processes against the Standards, there is generally no monitoring or surveillance between three-yearly site visits.
 - Some have suggested that this reduces confidence in the extent to which practices sustain conformance over a three-year period. However, the desire to minimise any additional or unnecessary impost on practices is also recognised.

Consultation questions

9. What are the strengths and limitations of the assessment approach?

10. How could the assessment process be improved, including to drive quality and safety, enhance confidence in the NGPA Scheme and minimise unnecessary burden?

Non-conformance and remediation

Within five business days of completing an initial accreditation assessment (the on-site assessment), an accrediting agency must notify the general practice in writing of the outcome of the initial assessment, including any matters that require remediation.²⁸ A general practice that has any mandatory indicators not met has up to 65 business days (90 calendar days) to complete remediation. Following this, the accrediting agency undertakes further assessment (usually conducted through a desktop review) and produces a final report describing the outcomes of the assessment.²⁹

Where a significant risk of patient harm has been identified during assessment, the accrediting agency is required to notify:

- the general practice, as soon as practicable – the practice must submit an action plan about how the risk will be addressed within two working days
- the relevant State and Territory health care complaints bodies and the Commission – the accrediting agency will also provide the practice’s action plan for addressing the risk.³⁰

Key issues on which the Review seeks stakeholder feedback include how best to:

- ensure that sustained conformance is achieved by practices throughout the three-year period of accreditation
- ensure the assessment process provides an accurate indication of the practice’s performance (in terms of safety and quality) and commitment to continuous improvement
 - Some stakeholders have suggested that a finding of non-conformance against the indicators does not necessarily mean poor performance but could in fact indicate a focus (by the indicators or surveyors) on administrative matters that are not critical to quality and safety.
- manage the risk associated with practices who may fail to meet the accreditation requirements but continue practising because the consequence of failure to obtain accreditation is a reduction in funding (i.e. inability to claim PIP) as opposed to a restriction on practice
- engage non-accredited practices in the accreditation process.

Consultation questions

11. What are the strengths and limitations of the current approach to non-conformance and remediation?

²⁸ Australian Commission on Safety and Quality in Healthcare, [Policy – Approval under the National General Practice Accreditation \(NGPA\) Scheme to conduct accreditation of general practices using the Royal Australian College of General Practitioners \(RACGP\) Standards for general practices](#), p. 26, clause 6.8.

²⁹ Australian Commission on Safety and Quality in Healthcare, [Overview of NGPA Scheme Factsheet](#).

³⁰ Australian Commission on Safety and Quality in Healthcare, [Policy – Approval under the National General Practice Accreditation \(NGPA\) Scheme to conduct accreditation of general practices using the Royal Australian College of General Practitioners \(RACGP\) Standards for general practices](#), p. 26, clause 6.7.

12. How could the approach to non-conformance and remediation be improved, including to drive participation in accreditation, sustained conformance and commitment to continuous improvement?

Cost of accreditation

As part of approval, accrediting agencies must advise the Commission if their proposed fee structure is based on a community rating (i.e. whether all practices pay the same price for the same product, regardless of the practice's location, size, other characteristics, etc.) or whether fees are quoted individually based on actual costs.

This is connected to requirements under the Standards to ensure that accrediting agencies do not:

- refuse an application for accreditation from a practice regardless of location or size
- financially or otherwise discriminate against a practice because of location or size.³¹

There is, however, no requirement to publish fees on an accrediting agency's website, to provide data to the Commission about fees charged or to comply with a set community rating/methodology for calculating fees charged.

While the Review does not have visibility of the actual fees or methodologies used by all accrediting agencies to calculate accreditation fees, based on anecdotal evidence it appears that some:

- charge a flat fee when a general practice registers for accreditation, with this cost linked to the number of FTE GPs working in the practice
- may charge additional fees to cover the expenses associated with surveyor travel and accommodation and/or the costs associated with undertaking the on-site assessment (variously calculated with reference to the number of hours on site, the sample size of health records to be reviewed, etc)
- charge a flat rate across all general practices (of like size), regardless of the location of the practice.

Separate to the actual cost of accreditation assessment, general practices also incur costs associated with the significant staff time spent preparing for accreditation assessment, achieving and maintaining conformance with the Standards and developing and maintaining sufficient documented evidence to demonstrate conformance.

The Review is exploring three main issues in relation to costs:

- **whether the direct costs of accreditation disproportionately impact certain general practices**
 - The cost of accreditation has been raised as a barrier to accreditation (particularly for rural, regional and remote general practices) where travel and accommodation costs may be significant. These costs may be greater where practices also deliver services through outreach sites, which are also subject to a site visit.

³¹ Royal Australian College of General Practitioners (RACGP), [Standards for General Practices](#), 5th ed, p. 6.

- Through the Review, we will seek to understand how significantly this is impacting different practices or limiting access to accreditation for certain types of practice, particularly very small practices, those in regional, rural and remote locations and those providing services to the most marginalised communities.
- Stakeholders have raised various options in relation to ensuring equity of access to accreditation. For example:
 - better defining how a community rating could be applied for general practice accreditation
 - requiring accrediting agencies to publish the fees charged to practices for accreditation
 - introducing increased Government funding to support the accreditation costs particularly for practices in regional, remote and rural locations (either through payments to these practices or through reimbursement of accrediting agencies' expenses)
 - specifying fees (based on the FTE of the practice) that accrediting agencies must charge (noting the impact of this on competition and the viability of accreditation agencies).
- **whether competition may drive discounting for certain types of general practices and/or a diminution in the quality of the accreditation process**
 - The commencement of the NGPA Scheme in 2017 has allowed additional accrediting agencies to enter the market. However, while there are five approved accrediting agencies, there remains two accrediting agencies that conduct the majority of accreditation assessments.
 - In any competitive market there can be variation in pricing, impacted by a range of factors. However, some stakeholders have suggested that:
 - some accrediting agencies may offer discounts to certain practices that may be easier to assess (for example, because the practice is in a metro area) while maintaining higher fees for practices that may be more challenging to assess (for example, practices in regional, rural or remote areas, practices that offer more diverse services, etc.).
 - the ability of some agencies to offer lower fees may reflect a decreased rigour of assessment or decreased focus on surveyor training and resources to support accreditation
 - some accrediting agencies may be able to reduce fees associated with assessment by offering accreditation services as part of a membership fee (i.e. access to policies, procedures, templates, etc.).
 - Recognising that accrediting agencies themselves are businesses and that any pricing model needs to be sustainable, a focus of the Review is whether fee structures are acting as an incentive or barrier to accreditation (for some or all practices) or impacting the quality and rigour of the assessment process.
- **whether there are opportunities to reduce the indirect costs of preparing for accreditation**
 - Early feedback to the Review has consistently identified the administrative burden for general practices in preparing for accreditation as a key issue, with many stakeholders noting that the preparation for accreditation falls predominantly to practice managers, administrative support staff and the nursing team.
 - Stakeholders have consistently described the impact of the indirect costs of preparing for accreditation on general practices – particularly in the staff time spent establishing and maintaining systems and compiling the documentary evidence required to demonstrate conformance with the Standards. Stakeholders have variously attributed this to the level of

prescription in the Standards themselves (see [the Standards](#)) and/or the assessment approach adopted (see [assessment approach](#)).

- While stakeholders noted the value of much of this preparatory work in reviewing and continuously improving the practice's systems and processes, they also noted opportunities to:
 - o reduce the focus on generation of documents purely for accreditation where these are not used by the practice for any purpose other than accreditation and do not feed into the quality improvement of the practice
 - o enable practices of different sizes and complexity to be able to demonstrate conformance differently. A number of stakeholders have noted that preparatory work is particularly significant for smaller practices with limited administrative support, as they are generally required to "do the same amount of work" to meet the Standards as a much larger practice. Stakeholders have also consistently noted the difference in capacity between hospitals in the acute sector (with teams dedicated to quality systems) and much smaller general practices
 - o better engage general practitioners and others in the accreditation process.

Consultation questions

13. *For accredited general practices:* Please describe the:

- a) direct costs involved in seeking accreditation (e.g. registration fees, travel and accommodation costs for on site assessment, etc.)
- b) indirect costs in seeking accreditation (e.g. costs of staff time preparing for accreditation, establishing systems and processes to meet the Standards, preparing evidence to demonstrate conformance with the Standards, etc.)

14. What are the strengths and limitations of the current approach to the setting of accreditation fees by accrediting agencies?

15. What changes could be made to the way that fees are set and levied to promote participation in accreditation and ensure equity of access across different types of general practice?

16. What adjustments could be made to the NGPA Scheme to reduce unnecessary costs associated with accreditation while continuing to ensure a focus on quality, safety and continuous improvement?

Data and transparency

Effective data reporting and analysis is also a critical component of any accreditation scheme. Data collection should include:

- ongoing analysis to:
 - understand the effectiveness of individual indicators within the Standards in changing practice and driving safety and quality
 - understand the performance of individual practice and accrediting agencies
 - identify trends over time

- inform policy and funding decisions
- enable the development of targeted resources, training and support for general practices
- understand risk at both the individual practice level and across general practices
- inform feedback loops to drive improvement, including to the Standards, the NGPA Scheme and general practice more broadly.
- collection for a clear and defined purpose (and avoid collecting data that is not used/needed)
- adequate protections of private and commercial information noting the sensitive personal, health and business information held by general practices and accrediting agencies
- different data available to different players in the governance arrangements to support them to perform their functions. For example, the Department and the Commission require data to assure quality and safety in general practice, while the RACGP requires data to inform improvements to the Standards (and to inform the support and guidance the RACGP provides to general practices).

Prior to the NGPA Scheme, there was little data collection either on the performance of general practices or accrediting agencies. Significant changes to data reporting over the last few years have been seen by some as a key success of the NGPA Scheme and by others as an unnecessary burden.

Some of issues relating to data, reporting and transparency which warrant further consideration as part of this Review include:

- **data and reporting requirements for accrediting agencies**
 - Some accrediting agencies have noted that a significant amount of information is reported to both the Commission and the RACGP, given the dual oversight of accrediting agencies. Some consider the data reporting requirements administratively onerous and questioned how the provision of the data connects to quality outcomes or improvement of the Standards.
 - Some reported that while the Commission and the RACGP require similar information from accrediting agencies, there are different systems, formats and templates for providing this information. Stakeholders have also queried how this data is used, including to monitor the performance of accrediting agencies, to inform adjustments to the Standards or to drive continuous improvement of the NGPA Scheme itself.
- **qualified privilege**
 - Qualified privilege is enabled under section 124X of the *Health Insurance Act 1973*. The intent of qualified privilege is to promote sharing of learning between practices, GPs and surveyors without fear of reprisal. Qualified privilege prohibits the disclosure of information that becomes known through a defined quality assurance activity, prohibits production to a court and affords protection from civil liability in respect of the activities.
 - Some of the issues for consideration include:
 - the need for qualified privilege in the context of an accreditation scheme, which relies on independent assessment by accrediting agencies and accountability to a scheme administrator (noting that it is not a feature of other accreditation schemes)
 - the impact of qualified privilege on the accuracy and completeness of data provided to the Commission. For example, the Commission is unable to communicate directly with general practices because the Commission receives only de-identified information about accreditation activities. This recently created challenges for the Commission in contacting general practices about extensions to accreditation certificates and the

suspension of accreditation assessments (due to COVID-19). It also means that the Commission's [post-assessment survey](#) is sent to the general practice by the accrediting agency rather than directly (with some practices noting the challenges associated with providing genuine feedback in this way) and that the Commission cannot be assured about the accuracy and currency of the information about accredited and non-accredited practices. Further, where the Commission undertakes observational visits of on-site assessments, the Commission must comply with specified non-disclosure requirements.³²

- **use of data to drive improvement**

- Given the recency of the introduction of data reporting requirements, there has been limited ability to utilise data analysis to identify:
 - areas of common non-conformance (including the reasons for this)
 - critical areas of safety and quality that require improvement either across certain practices or across the sector
 - linkages between accreditation outcomes and quality indicators (reported through the PHNs)
 - how to use different policy, program or funding levers to drive quality and safety in general practice (e.g. through changes to the PIP or the focus of PHN training and support).
- General practices receive assessment reports from accrediting agencies but do not otherwise have visibility of how they compare to other general practices in relation to performance under the Standards nor how the sector is performing as a whole. By contrast, PHNs make benchmarking reports available to practices in relation to quality indicators. A number of practices consulted in the early stages of this Review highlighted the value of benchmarking reports to help them to continuously improve.

- **transparency of accreditation outcomes**

- While accrediting agencies publish the name and location of the general practices they have accredited on their websites³³, there is no central register of general practices in Australia (including which practices are accredited). Some stakeholders have suggested this is important to enable patients to choose practices that are accredited, while others have noted the impact this may have in areas where there may not be an accredited practice. Other stakeholders have highlighted that publication of information could act as a deterrent to accreditation and were keen to ensure that any published information would not 'name and shame' practices but recognise those practices that invest in accreditation.

Consultation questions

17. What are the strengths and limitations of the current approach to data (reporting, analysis and use) and transparency?

³² Australian Commission on Safety and Quality in Healthcare, [Policy – Approval under the National General Practice Accreditation \(NGPA\) Scheme to conduct accreditation of general practices using the Royal Australian College of General Practitioners \(RACGP\) Standards for general practices](#), p. 25.

³³ Australian Commission on Safety and Quality in Healthcare, [Policy – Approval under the National General Practice Accreditation \(NGPA\) Scheme to conduct accreditation of general practices using the Royal Australian College of General Practitioners \(RACGP\) Standards for general practices](#), p. 27, subclause 7.1.2; see [ACHS](#); [AGPAL](#) (through a search of postcode); [QPA](#) (through a search of postcode).

18. How could the approach to data (reporting, analysis and use) and transparency be improved to drive quality, safety and continuous improvement by general practices and also in relation to the operation of the NGPA Scheme?

Intersection with other accreditation schemes

General practice accreditation is only one of many accreditation schemes that a practice may be required to comply with. There are different accreditation requirements if a practice delivers government funded programs/services, provides multidisciplinary care (for example, onsite allied health or dental care) and/or engages medical students, interns or GP trainees.

Stakeholders noted that:

- there can be significant duplication in the information provided as part of different accreditation processes and in the accreditation processes themselves, with different accrediting agencies conducting assessment (where there may be multiple site visits by different surveyors)
- practices often have to submit the same information in different forms as part of different accreditation processes, particularly in relation to the practice's profile and patient demographics
- there is a lack of recognition between accreditation schemes, including where information has already been provided to one body or is otherwise publicly available (for example, GP registration details that are accessible on the Ahpra website).

Case study – meeting multiple standards

One general practice located in a remote area in Queensland is currently accredited under seven different schemes, including:

- General practice accreditation against the Standards under the NGPA Scheme (every three years).
- Accreditation against the [Diagnostic Imaging Accreditation Scheme \(DIAS\) Accreditation Standards](#) – this is required for patients receiving diagnostic imaging services (such as ultrasound and radiography) to claim Medicare benefits and includes independent desktop assessment by an approved accreditor against 15 standards (every four years).
 - The State Government also requires the practice to hold a [medical radiation use licence](#) to use radiation (which must be renewed every three years) and to have the practice's equipment and premises certified against safety requirements through an on-site assessment by an accredited person (annually).
- Accreditation against the [Thoracic Society of Australia and New Zealand \(TSANZ\) standards for the delivery of spirometry for coal mine workers](#) to undertake spirometry (lung function) tests for the Coal Mine Workers' Health Scheme – this includes an independent desktop assessment by the accrediting body against 13 standards (annually)
- Accreditation against the [Accreditation Standards – Standards for the accreditation of medical intern training in Queensland](#) to host and train interns and junior doctors – this

includes independent assessment by the State's postgraduate medical council against 13 standards (varied, minimum of every four years).

- Accreditation against the [RACGP Standards for general practice training](#) and the [ACRRM Supervisors and Training Post Standards](#) to host and train GP trainees – this includes independent assessment by the regional RTO (every three years).
- Maintaining compliance with expectations set by universities (in line with the [Standards for Assessment and Accreditation of Primary Medical Programs](#)) to host medical students – requirements vary across the medical schools.

While stakeholders noted that accreditation schemes have different foci, they also recognised that there were opportunities for efficiencies. For example, efficiencies may be found by:

- centralising general practice profile information
- mapping the various accreditation schemes against each other to identify areas of mutual recognition.

Consultation questions

19. Describe any opportunities to reduce duplication across accreditation schemes impacting on general practices. For example, with training accreditation or accreditation to deliver additional health services.

Support for general practices

One potential barrier to a practice seeking accreditation is a lack of support to enable the practice to meet accreditation requirements (including to meet the Standards, demonstrate compliance with the Standards and prepare for accreditation assessment). This can be particularly so for sole or very small practices. Likewise, some practices can struggle with aspects of the Standards, such as clinical governance, quality systems, policies and procedures and demonstrating continuous quality improvement.

It is therefore important that any accreditation scheme includes support for general practices. This support does not need to be provided by accrediting agencies (who are independently assessing the general practice against the Standards) but may be provided by a range of other organisations, including peak bodies such as the RACGP and the ACRRM and PHNs.

A number of stakeholders noted that historically, Divisions of General Practice played a greater role in supporting general practices to meet accreditation requirements. However, with the transition to PHNs, this direct support has not been a priority for all PHNs.

It has been suggested that, while some support is available through peak bodies and PHNs, this:

- is not consistently provided across Australia
- is not always well coordinated
- is not well informed by data analysis, including understanding the areas in which general practice might need additional support

- can be costly for practices to access due to charges for training and/or because it takes from time spent with patients.

Consultation questions

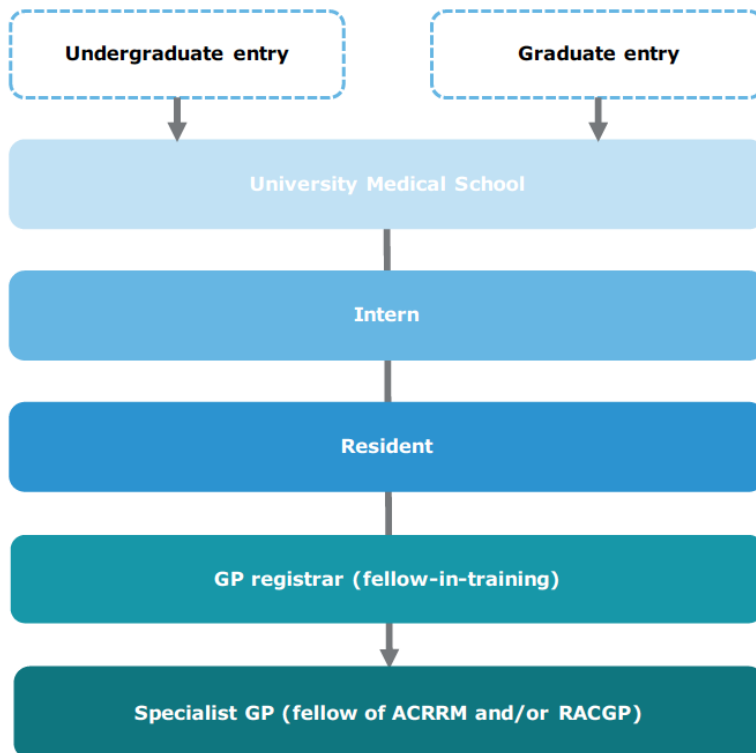
20. Describe any opportunities to improve the support available to general practices to drive engagement with accreditation and achievement of accreditation outcomes.

5. Training accreditation – background

Purpose and scope of training accreditation

Relevant qualifications for the speciality of general practice involve a pathway from primary medical training, through to prevocational training and then specialist medical training as a Fellow. These phases of medical training each involve distinct standards, curriculum and requirements.

Diagram 2: Pathway to becoming a general practitioner³⁴

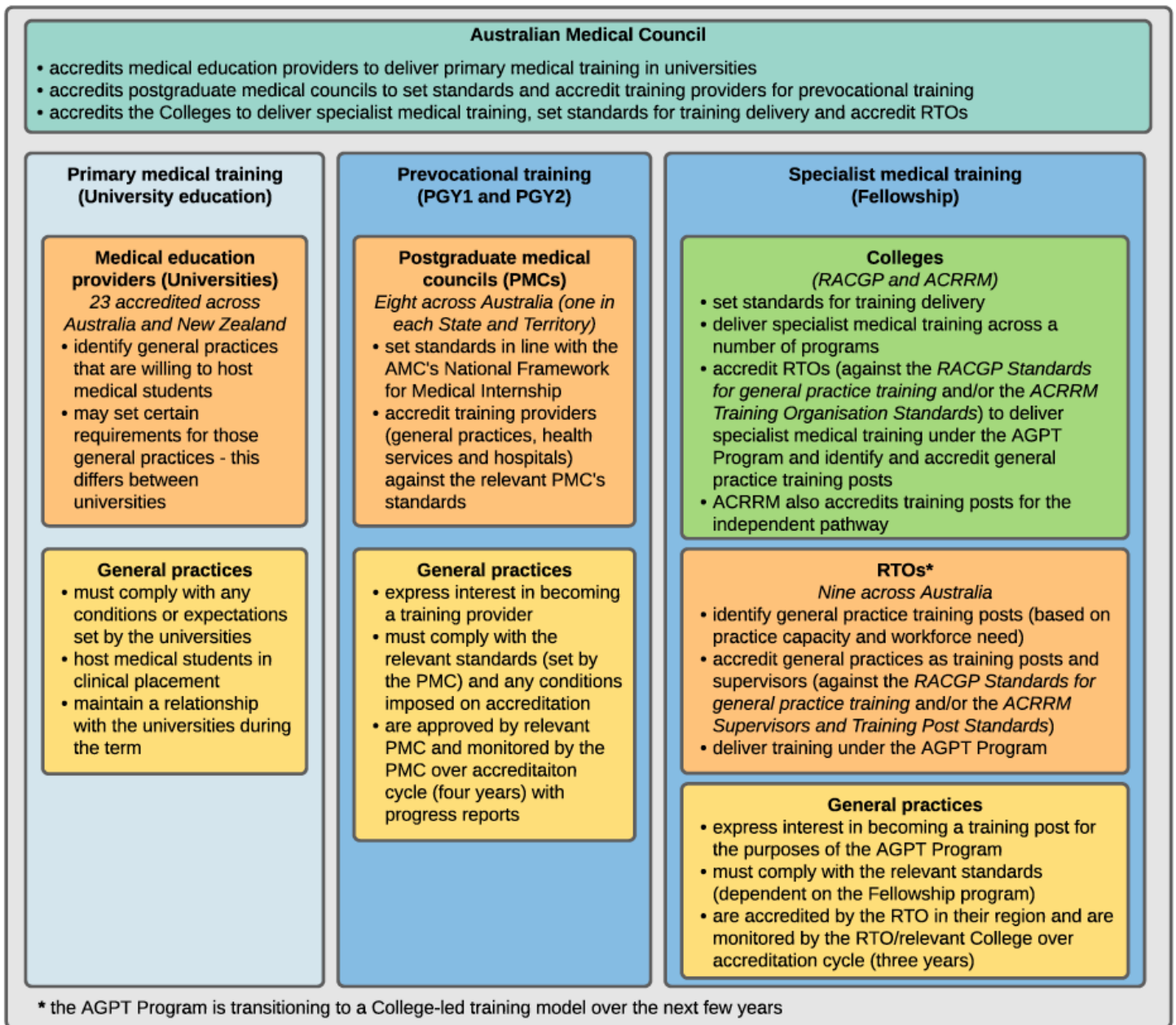


Learners across the spectrum, from primary medical training to specialist medical training, may be hosted by a general practice and supervised by GPs who are approved/accredited to provide a training environment for the learner.

In conjunction with the Medical Board, the Australia Medical Council (the AMC) oversees the standards of education, training and assessment of the medical profession, including general practitioners. As described below, the AMC plays a role in setting standards and expectations across primary, prevocational and specialist medical training.

³⁴ Drawn from Deloitte and Cornerstone Health Pty Ltd, November 2019, *General Practitioner workforce report 2019*, p.7.

Diagram 3: Overview of general practice training accreditation



Primary medical training

The AMC accredits medical education providers against the [Standards for Assessment and Accreditation of Primary Medical Programs](#). There are currently 23 medical education providers (i.e. medical schools within universities) registered with the AMC across Australia and New Zealand to deliver primary medical training.³⁵

As part of a program of study, a university is required to include a significant period of student contact with patients. This may include supervised clinical experience and education in a training site such as a hospital, community-based health facility, private practice or general practice.

³⁵ See the Australian Medical Council website, [Accredited medical schools](#).

Each university creates a framework in which to deliver this clinical experience and education and works with training sites to place students and set expectations regarding what supervision is required, what level of payment is available, and what experience medical students are entitled to expect. These frameworks vary between the universities.

Prevocational training accreditation

Prevocational training is broken into two periods – the first-year post-graduation from a medical school (PGY1) where postgraduates are known as interns and the second-year post-graduation (PGY2).

Under the Registration Standard set by the Medical Board, all interns are required to complete at least 47 weeks equivalent full-time experience as an intern in supervised clinical practice in an approved hospital, general practice or ambulatory locations.

The AMC develops national guidance and standards on internship on behalf of the Medical Board of Australia for the accreditation and monitoring of intern training, known as the National Framework for Medical Internship. This national framework is currently under review.³⁶

There are eight state-based intern training accreditation authorities (also known as postgraduate medical councils (PMCs)) accredited by the AMC.

The PMCs accredit intern training providers and their training programs against the relevant state-based standards developed by each medical council in line with the AMC's framework. PMCs accredit health services such as general practices, community health centres and hospitals as training providers and consider their capacity to host interns (and in some States and Territories, junior doctors in their PGY2 year). Each PMC applies their own standards and accredits through different accreditation processes.

On the completion of the internship period, junior doctors are eligible for general registration with the Medical Board. Training during the second year is less structured than the first, however some PMCs provide guidance to training providers regarding the expectations of the education and experience provided to PGY2 doctors.

Specialist medical training accreditation

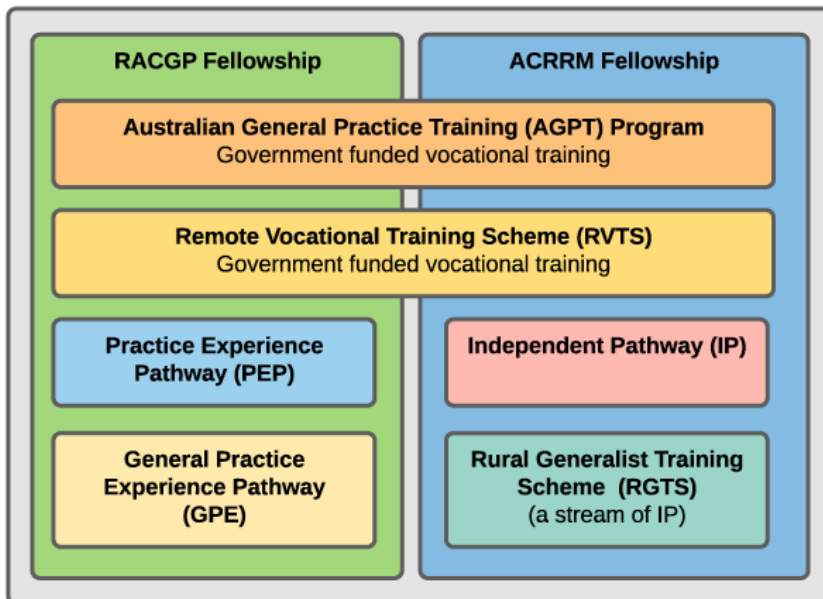
General practice as a speciality is awarded through completion of a three to four-year Fellowship training program.

The ACRRM and RACGP are accredited by AMC to deliver specialist medical training education through their respective Fellowship programs³⁷ and are recognised by the AMC as responsible for developing and maintaining standards of training for general practices in Australia and, where applicable, to accredit Regional Training Organisations (RTOs) to deliver the training on behalf of the RACGP and ACRRM.

³⁶ See the Australian Medical Council's website, [National Framework for Prevocational \(PGY1 & PGY2\) Medical Training](#).

³⁷ See AMC accreditation reports for RACGP and ACRRM: <https://www.amc.org.au/accreditation-and-recognition/accreditation-reports/>.

Diagram 4: Pathways to fellowship



The AGPT Program is the most common specialist medical training pathway for Australian doctors. While the Colleges set the curriculum and assessments for registrars under the fellowship training program, RTOs are funded to deliver training under the AGPT Program.

Overview of the AGPT Program

The AGPT Program is a Government-funded training program that pays the training costs for 1,500 training places across Australia each year.

There are nine RTOs that occupy one or more of the 11 training regions across Australia for the purposes of the AGPT Program. The RTOs are funded by the Department to accredit training posts against the RACGP and ACRRM training standards.

The Colleges set standards for RTOs ([RACGP Standards for general practice training](#) and the [ACRRM Training Organisation Standards](#)) and accredit the RTOs against these every three years. The Department contracts RTOs to deliver specialist training under the AGPT and the Colleges contract RTOs to deliver specialist training under the PEP.

The RTOs, in turn, identify and accredit training posts (including general practices) and supervisors within those training posts against the College-set standards [RACGP Standards for general practice training](#) (the RACGP training standards) and/or the [ACRRM Supervisors and Training Post Standards](#) (the ACRRM training standards).

GP trainees apply for the AGPT Program through the Colleges and identify preferred training regions. The Department requires that registrar training is distributed, with a target of a minimum of 50% of a registrar’s training occurring in regional locations (based on MMM 2-7).³⁸

³⁸ Department of Health, *Australian General Practice Training (AGPT) Program Policies 2020*, p.2.

6. Training accreditation – key issues for consideration

Context

At the time of writing, the general practitioner training environment is undergoing significant change, including:

- the transition to College-led specialist medical training delivery and accreditation for the Fellowship programs
- reviews being undertaken by the AMC in relation to prevocational training and primary medical training
- the shift from PGY1 standards to a further structured learning for PGY2 (to cover the two prevocational years) for those postgraduates who do not wish to enter specialist medical training at the end of their PGY1.

This Review is therefore focusing specifically on:

- specialist medical training post accreditation (of general practices) through the AGPT Program
- intersections between general practice accreditation and training accreditation, particularly in terms of the impact on general practices
- opportunities for improvement, including how these might be implemented through the transition.

Benefits of, and barriers to, training accreditation

Based on stakeholder feedback to-date (and relevant literature) some of the key benefits of training accreditation include:

- supporting practices to facilitate a quality training experience for registrars
- maintaining standards of training across Australia and ensuring consistency of experience across training environments
- access to a registrar workforce
 - Having a registrar undertake training at the practice brings income to a practice and may also encourage that registrar to consider ongoing employment with that practice, helping to address any workforce shortages (which is particularly important for practices in regional, rural and remote locations).

Some of the barriers to general practices becoming accredited for training include:

- the competitive nature of registrar placement
 - Stakeholders have reported that the key barrier to accreditation is the limited availability of registrars. As such, some RTOs only accredit a finite number of practices – to ensure that those practices can maintain a relatively steady ‘flow’ of registrars, and don’t undergo accreditation for no reason/outcome. Some RTOs will not accredit general practices where there is no demand in the region for registrars (and as such, registrars are unlikely to be placed there).

- Some stakeholders have suggested that decision-making around the placement of registrars is not always equitable or based on merit and that conflicts of interest may influence decision-making.
- limited incentives or financial gain for becoming accredited
 - While practices receive some Government funding to employ registrars (e.g. supervisor allowances and subsidies), some stakeholders have reported that these do not offset the cost of onboarding GP trainees/registrars and as such, training registrars is often an ‘altruistic endeavour’.
- the direct and indirect costs of undergoing assessment, including:
 - the paperwork required of general practices to meet the training standards
 - concern that investment in systems and processes to support accreditation will not necessarily be rewarded by the placement of a registrar with that practice
 - the costs to the practice of supervising a registrar, including the impact on the capacity for supervisors to see patients (and consequently on income to the practice)
- duplication of effort in demonstrating conformance with the Standards for general practices and the training standards.

Consultation questions

21. What are the benefits of, and barriers to, training accreditation?

Key issues

Many of the issues described in relation to general practice accreditation also apply with respect to training accreditation. For example, it is important that:

- there is clarity of the purpose and outcomes sought through accreditation, as well as roles and responsibilities
- the standards are appropriate and fit for purpose
- stakeholder engagement informs the training accreditation standards and processes
- the individuals or bodies undertaking assessment are suitably skilled and qualified and free from bias or conflicts
- the assessment is of adequate depth and has an appropriate focus
- practices can have confidence in the consistency of assessment
- there is adequate monitoring and surveillance between assessments to ensure sustained conformance with the requirements
- non-conformance is addressed and remedied and any risks to students and patients are managed
- the costs of accreditation (either direct or indirect) do not outweigh the benefits to practices
- data is collected and analysed to inform improvements within individual practices and across practices.

Noting these similarities, this chapter focuses on those issues that are particular to training accreditation.

- **Clarity of purpose, roles and responsibilities**
 - The purpose of training accreditation (and the outcomes sought) are clearly articulated in the RACGP training standards: “These processes ensure that the GPs who complete the training program can practise unsupervised anywhere in Australia and meet the highest standards of quality and safety expected by the Australian community”.
 - Currently, the Colleges have different approaches to working with RTOs to accredit practices and train registrars. The RTOs themselves also have varying approaches to determining which practices may undergo training accreditation, based on factors including the workforce need in the area, the size and makeup of the practice (including the availability of suitable supervisors), whether the practice is accredited, etc.
 - Stakeholders have identified that RTOs play multiple roles and that there is currently no delineation between accreditation and workforce distribution such that considerations regarding workforce spread can impact the accreditation of a general practice. Others have highlighted this as a benefit of the current approach.
 - With the transition to College-led training, there will be significant changes to the governance arrangements, including the roles and responsibilities of the RACGP and ACRRM. While some stakeholders have highlighted that this may result in a more consistent approach to the selection and assessment of practices across Australia, others have queried:
 - how national bodies will ensure they have the necessary local knowledge to inform workforce need across their training region and to provide support to supervisors and trainees
 - how Colleges will ensure their different roles (training, oversight of accreditation, assessment of practices, membership body) are differentiated to support confidence in the scheme.

- **Intersection of standards**
 - While some stakeholders have highlighted the overlaps between the Standards for general practices and the training standards, others have reported that they focus on quite different matters as relevant to the provision of training.
 - At a high level, it is desirable:
 - for there to be clarity regarding the intersection between the Standards for general practices and the training standards
 - to minimise the need for general practices to demonstrate conformance with similar requirements multiple times or in different ways under different accreditation schemes.
 - Stakeholder advice is sought regarding how this might be achieved in the future.
 - Some stakeholders have suggested the development of a modular set of standards, which includes ‘core’ standards applicable to all practices and additional standards applicable to practices that would like to deliver training (with all forming one cohesive set of standards).
 - Others have suggested changes could be made to assessment processes to enable practices to demonstrate conformance through a combined assessment process, submission of one set of data or information or through coordination of site visits across accreditation schemes.

- **Requirements for accrediting bodies**
 - RTOs are accountable to both the Department (through a funding agreement) and the Colleges (through agreements and/or standards).
 - Noting the transition to College-led training and changes to RTOs arrangements, the Review seeks to understand what can be learned from experience and what this means for:

- the oversight required of those undertaking assessments, including to ensure consistency of assessment, management of potential conflicts and to continue to build confidence in the independence and quality of assessment
- the skills and qualifications required for the assessment workforce, including to ensure that assessors understand the general practice context, best practice assessment methodologies (common across accreditation schemes) and the unique issues associated with training posts and supervisors.
- **Assessment approach**
 - Currently, the assessment approach differs between RTOs and across regions.
 - While different practices report different experiences of accreditation, key issues for consideration in the context of the transition include:
 - consistency of assessment
 - the depth and focus of assessment
 - minimising duplication between general practice accreditation assessment and training accreditation assessment
 - reducing unnecessary burden associated with the training accreditation assessment process.
 - To minimise impact on practices, some RTOs currently undertake a single assessment against both the RACGP training standards and the ACRRM training standards. Stakeholders have suggested that the ability to combine assessments or share assessment information between the Colleges to reduce the impact of training accreditation should be considered as part of the transition.
- **Continuous improvement, drawing on the feedback of practices, supervisors and registrars**
 - Some stakeholders have described the challenges in registrars providing genuine feedback about the quality of the training provided by the practice and/or supervisor.
 - Registrars require sign-off from the practice to meet their Fellowship requirements and may therefore be less likely to raise complaints directly with the practice, their supervisor or through the RTO.
 - Given that practices often have only one registrar at a time, any feedback can easily be linked to the individual, which may act as a disincentive for registrars making complaints. Where a registrar moves between practices (including because of a poor training experience), this may also impact their ability to meet training requirements within the timeframes expected.
 - Stakeholder advice is sought regarding how feedback and other data might be better used to feed into accreditation decisions and support continuous improvement for practices providing training.

Consultation questions

22. What are the strengths and limitations of the current approach to training accreditation through the AGPT Program?

23. How could the approach to training accreditation through the AGPT Program be improved under the transition to College-led training and accreditation to:

- ensure clarity of purpose, roles and responsibilities
- improve consistency of assessment and drive confidence in training accreditation

- reduce duplication between requirements and accreditation processes
- reduce conflicts between the placement of registrars based on workforce need and accreditation
- use learner feedback to inform accreditation decisions and continuous improvement
- ensure training posts are best able to support learners and provide a quality training environment?

24. Describe any opportunities to combine certain aspects of general practice accreditation and training accreditation to reduce the burden on general practices and improve the experience for supervisors and learners.

25. *For general practices that are accredited for training:* Please describe the:

- a)** direct costs involved in seeking accreditation (e.g. registration fees, travel and accommodation costs for on site assessment, etc.)
- b)** indirect costs in seeking accreditation (e.g. costs of staff time preparing for accreditation, establishing systems and processes to meet the training standards, preparing evidence to demonstrate conformance with the training standards, etc.)