MEASUREMENT OF THE QUALITY OF GENERAL PRACTICES IN AUSTRALIA

GRAEME C MILLER

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Any inquiries about this publication should be directed to:
Family Medicine Research Centre
University of Sydney
Acacia House
Westmead Hospital
WESTMEAD New South Wales 2145
Phone: 61 2 9845 8151
Fax: 61 2 9845 8155
Email: gmiller@med.usyd.edu.au

This thesis is dedicated to the late

Dr Bill Corlis

General practice and medical education guru

He shaped the general practitioners who shaped Australian general practice

ABSTRACT

This thesis describes the development of the Entry Standards for General Practice by the Royal Australian College of General Practitioners (RACGP) and the results of the Field Test of the Entry Standards (directed by the candidate).

The quality of health services - encompassing both the quality of clinical care and the cost/benefit delivered to individuals and to the community - has become the subject of intense scrutiny by bureaucrats, health planners and administrators, academics and consumers.

The increasing realisation of the large part played by primary medical care (general practice) in determining costs in the secondary and tertiary sectors has led to pressure to improve general practitioner 'efficiency' while maintaining 'quality'.

The perceived effect on health care of the functionality of the basic organisational unit of primary medical care, the 'general practice', led to a proposal by the Australian Government in 1991 to introduce a process of accreditation of general practices.

In response to this proposal the RACGP formed a Standards Working Party to develop 'entry standards' for an accreditation process and the standards were subsequently field tested in 200 practices.

The Field Test demonstrated the face validity of the Entry Standards, their acceptability to general practitioners and their achievability in Australian general practice. The acceptability and feasibility of a peer review based pilot accreditation process was also demonstrated.

Following the Field Test the Entry Standards were further refined and subsequently adopted by the RACGP as the 1996 Entry Standards for General Practices and released for use as a tool for improving the standards of general practices through education, self assessment and accreditation.

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The process which led to this thesis would not have been possible without the support and tolerance by my wife Yvonne of the multiple changes to my career pathway in pursuit of academic goals.

I would not have attempted this endeavour without the encouragement and support both professional and personal of my supervisor Helena Britt. She led me by the hand through the mirror between clinical and academic general practice and filled me with her own enthusiasm for the craft of research. I could not have completed it without her perseverance and faith.

The work this thesis reports grew out of the quality ethos of the Royal Australian College of General Practitioners and was supported by senior officers of the College in particular Michael Bollen and Barbara Booth. Both also gave me personal support and encouragement. Personal thanks for support also go to Eric Fisher, the GP's GP.

Special thanks go the other research staff of the Standards Development Unit: John Stirton, Project Manager and Senior Researcher; David Smith and Maria O'Brien, Senior Research Assistants; and Jenny Yeun, Karissa Hayhurst, Helen Wilson, Danika Mayne and Kerry McAuley, research and clerical assistants. All performed above and beyond the call of duty and helped make the Unit an effective integrated research team.

The Standards Working Party consisting of Barbara Booth, Bruce Harris, Jill Gordon, Mark Harris, Michael Crampton, Richard Hays, Liz Harris, Jim Dickinson, Ian Wilson and the candidate was responsible for the development of the Entry Standards for General Practice.

Computer programs to facilitate data entry and analysis were created by Arron Davies. The surveyor education program was designed by Richard Hays and implemented by Philip Godwin. Helena Britt and Geoff Sayer provided valuable methodological and statistical advice.

Grateful thanks go to all the GPs in the 199 practices in the Field Test for their cooperation and enthusiasm and to the surveyors who visited the practices and provided the research team with so many useful insights.

I also acknowledge the significant funding provided by the General Practice Branch of the Commonwealth Department of Health Housing and Community Services (as it was then known) and the efforts of the responsible Department Officers, Gail Batman and Patrick Colmer to assist with the project.

My thanks go to the Council of the College for authorising my access to all the data collected during the Field Test for the purpose of preparing this thesis.

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GLOSSARY OF TERMS AND ABBREVIATIONS

accreditation	In this thesis accreditation is a process that a general practice undergoes to demonstrate compliance with standards.
AMA	The Australian Medical Association.
contact doctor	A general practitioner designated as the contact with the research team by a practice participating in the Field Test
criterion	In this thesis a criterion is a statement which describes a key component of a Standard.
desirable criteria	These criteria describe components of a standard and may cover areas where there is not firm evidence or a clear consensus of what constitutes good practice.
DHHCS	Department of Health, Housing and Community Services of the Australian Federal Government. Now known as the Department of Health and Ageing.
DHHLGCS	Department of Health, Housing, Local Government and Community Services of the Australian Federal Government. Now known as the Department of Health and Ageing.
division	In this thesis a division is an organisation of general practitioners covering a defined area in Australia, usually funded by the Commonwealth Department of Health and Family Services. There are approximately 120 Divisions of General Practice in Australia.
essential criteria	These are criteria which must be met in order to meet a Standard. They are marked with an * in the Standards document and in tables and reports in this thesis.
Field Test	The RACGP Field Test of the Entry Standards for General Practice
FMP	Family Medicine Programme, a post-graduate training course in general practice conducted by the RACGP.
FRACGP	Fellow of the Royal Australian College of General Practitioners.
general practitioner (GP)	A medical practitioner who “provides primary comprehensive and continuing care to patients and their families within their community” (Royal Australian College of General Practitioners).
global judgement	A form of practice evaluation in which surveyors were asked whether or not the practice *deserved* to be accredited regardless of their performance on the standards. This provided an alternative measure of ‘good’ versus ‘bad’ practices.
HIC	Health Insurance Commission, Canberra.
indicator	In this thesis an Indicator is a description of an element of a criterion that is measured or assessed by a surveyor to determine if a practice complied with a criterion.
individual assessment	Each surveyors individual assessment of a practice for each of the 65 criteria where judgement could fall into ‘substantial’, ‘partial’, ‘nil’ or ‘not applicable’.

joint assessment	The surveyors jointly agreed assessment of a practice for each of the 65 criteria, where judgement could fall into 'substantial', 'partial', 'nil' or 'not applicable'.
NHMRC	National Health and Medical Research Council.
NSW	The State of New South Wales.
practice	In this thesis a practice is a self identified organisational unit of general practitioners which is assessed against the standards. It usually consists of one or more general practitioners housed in one or more buildings who share medical records and/or patients.
Qld	The State of Queensland.
RACGP	The Royal Australian College of General Practitioners.
RARA	Rural and Remote Area classification of the Department of Human Services and Health.
SA	The State of South Australia.
sample doctor	A general practitioner in the stratified random sample used to select practices to participate in the Field Test
SRG	Standards Reference Group of the RACGP.
standard	In this thesis a standard is a statement which describes the qualities required for particular practice activities or attributes.
surveyor	In this thesis a surveyor is a general practitioner who has been trained to undertake practice visits to assess compliance with the standards. In the Field Test each practice was visited by a team of two surveyors.
Tas	The State of Tasmania.
Vic	The State of Victoria.
vocational registration (VR)	A system to register general practitioners who have attained standards of knowledge and skills in general practice sufficient to practice independently and unsupervised (Royal Australian College of General Practitioners).
WA	The State of Western Australia.

CHAPTER 1

AIMS OF THIS THESIS AND THE CANDIDATE'S CONTRIBUTION

Aims

- To describe the development by the Royal Australian College of General Practitioners (RACGP) of standards for use in a system of practice accreditation.
- To test the use of the RACGP Entry Standards for General Practice in measuring the quality of a random sample of Australian general practices and to investigate the extent to which those Standards are perceived as valid, acceptable and achievable by Australian general practitioners and other stakeholders.

Summary of the contribution of the candidate to this research project and thesis.

The research reported in this thesis was a major national study conducted under the auspice of the RACGP and funded by the Australian Department of Health, Housing and Community Services.

As full-time Director of the project, the candidate was fully involved in all aspects of the conceptualisation, research design, planning, initiation and conduct of this research.

The overall aims of the Field Test of the RACGP Entry Standards for General Practice were set initially by the RACGP Interim Standards Working Party (ISWP) with a substantial contribution from the candidate.

As full-time Director of the Standards Development Project from January 1994 until its completion, the candidate assumed full responsibility for the conduct of the Field Test.

The research questions and research design were formulated by the candidate with input from the research team, the ISWP and external consultants, Dr Helena Britt, Mr Geoffrey Sayer and Professor Andrea Mant.

Sample size and stratification were based principally on statistical advice to the candidate from external consultants, Mr G Sayer, Dr D Tyson and Ms L Kehoe. The final sample size was determined in negotiation with DHSH by the candidate, taking into account the constraints imposed by both funding and the time frame for the Field Test.

Statistical analysis was determined by the candidate with the assistance of the research team and advice from Mr G Sayer. Data analysis was undertaken by the research team under the supervision of the candidate.

General practice and surveyor sample selection was determined by the candidate with the advice of Mr J Stirton and Dr H Britt.

The surveyor training program was designed by Professor R Hays to specifications determined by the ISWP with substantial input from the candidate. Training sessions were facilitated by Professor Hays and Dr P Godwin. The candidate supervised all training sessions and conducted the sections covering interpretation of the Standards.

Data entry was carried out by the research team under the supervision of the candidate.

The literature review, background, interpretation of the results of the Field Test, and discussion presented in this thesis are exclusively the work of the candidate.

Candidate's contribution

The candidate has been involved to varying degrees in the measurement of quality in general practice for over two decades. This thesis describes the culmination of his work in this field. The candidate's

contribution to the development of standards in general practice commenced with his membership of the Education Committee of the NSW Faculty of the RACGP from 1973 - 1982 and exposure to the educational philosophy of the late Dr Bill Corlis, Postgraduate Fellow of the Faculty. From 1974 to 1977 the candidate was a member of the Accreditation Committee of the Faculty which was responsible for the accreditation of practices teaching trainees in the RACGP Family Medicine Program, the College's fledgling vocational training program for new graduates wishing to enter general practice. In 1978 his interest in the administration and structure of practices as a factor in the delivery of quality care led him to join the NSW Faculty Practice Management Committee of which he became Chairman in 1981, joining the National Practice Management Committee as a result. He continued on the National Committee until 1987 taking a particular interest in standards for office and patient held medical records.

In 1983 his interest in pursuing the development of quality initiatives at the national level led to his election to the Council of the RACGP of which he became Chairman in 1984.

In 1985 he was a member of a NSW Faculty working party developing the framework for a national continuing education and quality assurance program for members of the College. In 1986 he was a member of the national working party which produced the Quality Care plan which was ratified by the Council of the College in October 1986, introducing mandatory continuing education and quality assurance procedures for members of the College. Included in this program was a practice structure (facilities) questionnaire, the first attempt in Australia to assess the standard of the practice rather than the general practitioner. In early 1987 a Quality Care Committee of Council, with the candidate as a member, was formed to oversee the continuing development of the 'Quality Care' program of the College.

In 1986 he was appointed Honorary Secretary of the RACGP and had particular responsibility for promoting the College policy for the introduction of vocational registration of general practitioners and the introduction of mandatory training before entry into unsupervised general practice. The candidate was jointly responsible for negotiations with the Australian Government which led to the introduction of vocational registration for general practitioners in 1989. The vocational registration regulations introduced mandatory training for doctors entering general practice and extended the College mandatory quality assurance and continuing education program to all vocationally registered general practitioners in Australia.

From 1990 to 1994 the candidate was the RACGP representative on the Australian Council on Healthcare Standards (ACHS) and from 1992 was chairman of the ACHS Standards Committee responsible for the development of standards for hospital accreditation.

In June 1991 the candidate participated in a 'General Practice Financing Think Tank' convened by Professor Bob Douglas of the National Centre for Epidemiology and Population Health at which the concept of practice accreditation was explored.[1] The concept was taken up by the Federal Government in the budget in August 1991.[2] In 1992 the candidate was co-author of a paper 'Accreditation of General Practices: Medical Perspectives' in the monograph 'Everyone's Watching: Accreditation of General Practice' which considered various aspects of accreditation of general practices.[3]

During late 1991 and 1992 the candidate was an RACGP representative on the General Practice Working Group (comprised of the RACGP, the AMA and the Commonwealth (then) Department of Health, Housing and Community Services) in the development of the principles of accreditation set out in the joint publication 'The Future of General Practice: A Strategy for the Nineties and Beyond'.[4] In November 1992 an Interim Standards Working Party, with the candidate as a member, was formed by the RACGP to develop practice standards that might be used in an accreditation process.

Commencing in December 1992 the Interim Standards Working Party developed a series of 'draft interim standards for accreditation of general practices'. A final draft for field testing was complete by December 1993 after extensive consultation. The Working Party was assisted in this development by the Standards Development Unit established by the RACGP with Government funding.

In December 1993 the candidate undertook visits to several general practices as part of the pilot program to develop indicators of compliance for the standards and to develop a visit protocol to be used in the subsequent Field Test of the Standards.

In January 1994 the candidate was appointed Director of the RACGP Standards Development Project. He was chief investigator responsible for the conduct of the Field Test of the draft RACGP Entry Standards for General Practice which forms the basis of this thesis. The candidate was responsible for the development of the research plan in conjunction with the Standards Working Party and outside consultants, conduct of the project, direction of research and administrative staff hired specifically for the project, and for the analysis and reporting of the results of the Field Test. Under the direction of the candidate logistic management was undertaken by Mr John Stirton and Ms Maria O'Brien and statistical analysis was programmed by Mr David Smith with the assistance of statistics consultant Mr Geoffery Sayer of the Family Medicine Research Unit (now the Family Medicine Research Centre), University of Sydney. The candidate was lead author of the final report of the project. Co-authors were J Stirton, D Smith and M O'Brien. Data entry was undertaken by Jenny Yeun, Karissa Hayhurst, Helen Wilson, Danika Mayne and Kerry McAuley.

The majority of this thesis is based on the results of the Field Test, a unique endeavour to test standards and measure the quality of general practices in Australia.

CHAPTER 2

INTRODUCTION AND BACKGROUND

Introduction

One of the first initiatives designed to promote the provision of safe, ethical and effective health care was codified in Athenian Greece by Hippocrates. This early measure concentrated on the ethical relationship between patient and doctor and the reduction of patient risk in a situation where potential therapeutic benefit was extremely limited. Over the succeeding centuries most attempts to improve care focussed on the training and attributes of the practitioners of the healing arts. In the United Kingdom this led to the formation of the medical royal colleges. The medical colleges functioned like the trade guilds in that they developed training by apprenticeship and a closed shop system to deter untrained persons from practicing medicine. Subsequently medical registration authorities were established, such as the General Medical Council in the United Kingdom (1858) and the various State Medical Boards in Australia, with the responsibility to determine and monitor the competence and conduct of medical practitioners. The focus on the training of the practitioner continued in the reforms to medical education triggered by the Flexner Report in the United States in 1910.[5]

'Quality of care' is a relatively recent term in the history of health care, becoming common in the literature only in the 1950s. The term 'quality of care' includes multiple related concepts and determinants of various aspects of health care. Assessing quality of care is a judgemental process differentiating between 'good' and 'bad' and may be based on the differing perspectives of the various players in the health care system. Thus practitioners, patients, health care organisations, governments and funders may bring different belief systems to the assessment process. The perspective will change also with the object of the assessment be it practitioner, practice, regional authority or health care delivery system and whether it is directed towards individual patient care, practice population care or care of the general community. Assessing the determinants of quality of care adds another dimension. This may require scrutiny of the precursors of the knowledge, skills and attitudes of practitioners such as cultural background, schooling, medical undergraduate teaching, vocational training and continuing professional development. The physical and organisational attributes of the health care environment will also play a significant part in determining quality from various perspectives. Thus assessing and improving quality of care is a complex mosaic of differing perspectives and multiple parameters. Any program designed to improve quality of care must address all the significant determinants or risk falling short of community and professional goals.

The history of quality development in health care has been a slow realisation of the complex interactions in the health care system and an awakening awareness that simple 'fixes' are in general unrewarding.

In 1966 Donabedian divided quality of medical care into three components, structure, process and outcome, for the purpose of evaluation.[6] Watkins added access as an important component of primary health care quality[7] and Starfield developed further sub-categories to facilitate measurement of the many facets of primary care quality.[8] These developments have made the measurement of the various aspects of quality much more systematic.

The quality of health services - encompassing both the quality of clinical care and the cost/benefit delivered to individuals and to the community - has now become subject to intense scrutiny by bureaucrats, health planners and administrators, academics and consumers. The perceived need to contain health care costs while increasing quality of care has spawned a sub-industry in health care related to the measurement of the cost and quality of services and analysis of the inter-relationship between the two. The impact of developing technology on costs in the secondary and tertiary sectors has resulted in a large public investment in processes to determine cost/benefit of interventions and promote rational decision making about resource allocation. The success or otherwise of this process in the hospital sector is beyond the scope of this thesis.

The first expression of real concern regarding the quality of general practitioner services was contained in a benchmark report on British general practice by Collings, an Australian GP visiting the United Kingdom, in 1950.[9]

Collings' study of British general practice was a pioneering piece of ethnographic methodology in social research.[10] He studied a variety of industrial, urban-residential and rural practices in great detail, describing their structure and function. He concluded that the state of British general practice was unsatisfactory and that its defects arose from a failure to define general practice and to establish and maintain standards. He found little coordination between general practice and other health services and that the future of general practice was determined mainly by people responsible for hospital and specialist development without deliberate consideration of the problems of general practice. He also stated "… bad conditions of practice can, do and will continue to negate the most conscientious teaching efforts…" and concluded "Against this background…refresher courses with paid locums, and trainee-ships – are of very little value as attractions or as a method of raising standards."

Collings damning indictment of general practice created an immediate sensation and was described by Petchey as "a turning point in the postwar history of British general practice".[10] The Collings report was a significant factor in the formation of the Royal College of General Practitioners (RCGP) two years later,[11] from which many of the quality initiatives in British general practice have sprung.[12-20] While Collings' methodology has been criticised, the report is widely seen as an important contribution to mobilising change.

In spite of Collings' comments on 'refresher courses' and subsequent research demonstrating the questionable value of much continuing medical education[21-23] the major quality initiatives in general practice promoted by the profession have until recently centred on vocational and continuing education.

In the early 1950s another Australian GP, WA Connolly, was also in the United Kingdom to study the function of group practice in that country. His investigations brought him into contact with Dr John Hunt and others interested in establishing a College of General Practitioners, modelled on the older specialist colleges, to try to improve the quality of British general practice and address some of the problems revealed by the Collings report. Connelly supported the formation of the British College in a letter in the British Medical Journal published on 23rd August 1952. He obtained permission from the British College to establish a Faculty of the College in New South Wales on his return to Australia. Subsequently other Faculties were formed in Australia followed by an Australian Council and an Australian College which became the Royal Australian College of General Practitioners (RACGP).[24]

When the RACGP was founded its main charter and mandate was to improve and maintain the standards of care delivered by general practitioners to the Australian community. The founders of the College sought to do this by introducing:

- educational programs for established general practitioners and those junior medical officers who wished to enter the discipline

- an examination for Fellowship of the College so that general practitioners could test their competence against their peers.

In the early 1970's the College established a formal vocational training program, then called the Family Medicine Programme, to further encourage the improvement of standards by providing structured training for junior medical officers before they entered practice. While the College Fellowship exam was available to trainees it was not a mandatory end point and only a minority tested their competence against the College standards. By the mid 1980's the number attempting the College exam had declined to a fairly low level.[25]

In parallel with these educational initiatives, the RACGP developed a medical record system for general practice based on the work of Laurence Weed which had demonstrated the vital role of medical records in the provision of high quality care.[26-29] The record system was promoted as a means of improving patient care and improving practice efficiency.

In the mid 1980's the College actively promoted the concept of vocational registration of GPs as a method of providing an incentive for junior medical officers to undertake training before going into general practice. Vocational registration was introduced in 1989 as part of the negotiations for the introduction of a new fee schedule with increased rebates for services provided by vocationally registered GPs. Fellows of the College and general practitioners with more than 5 years experience were granted vocational registration through a 'grandparent' clause in the Health Insurance Act.

Completion of the College training program and the Fellowship exam were set as the requirements for vocational registration for future entrants to the discipline.

This process provided a financial incentive for graduates to undertake training. The results in terms of the number of trainees entering the College training program and the number of trainees sitting the Fellowship examination have been substantial with the number of examination candidates rising from 173 in 1987 to 1000 in 1994.[25;30]

Training for individuals through the College training program and assessment of their knowledge, skills and attitudes by the College examination provided the potential for the delivery of improved quality of care.[31] Other measures were required to reinforce this potential. The first of these was the introduction of a program of quality assurance and continuing education for individual practitioners. Before the introduction of vocational registration the program had been introduced as a mandatory requirement for members of the College. This was incorporated as a requirement for general practitioners joining the Vocational Register. The aim of the RACGP Quality Assurance and Continuing Medical Education program is to maintain and further improve the skills imparted to doctors during the process of vocational training and to maintain and develop the skills of practising GPs.

The RACGP vocational training program[32] and the Quality Assurance and Continuing Education Program[33], in common with similar programs in other countries, seek to ensure the competence of individual general practitioners. Pereira Gray found it difficult to measure the effect of training in the United Kingdom in the absence of adequate criteria for determining quality.[34] In Canada, Borgiel found evidence that family medicine residency training was associated with higher scores for quality using a variety of measures and Woodward found differences in practice style consistent with the objectives of training.[35;36] Dunn however found little correlation between similar measures and the doctors CME activities.[21] Davies et al on, the other hand, found a positive correlation between CME and improved physician behaviours in meta-analysis of a large number of studies, although there was rarely a demonstration of improved patient outcomes.[22;23;37]

Background to accreditation of general practices

While Collings' criticisms of general practice in the United Kingdom in 1950 received much attention both in the United Kingdom and in Australia, his carefully elucidated solutions and recommendations received scant attention at the time or indeed subsequently. His clear perceptions of the structural problems of general practice are well described in the text. For example:

> "There is no doubt that the volume of work is too great, but this is merely a secondary factor. If the doctors' surgeries were better from a functional point of view; if they were equipped at least to some minimal standard; if a little order was brought into the chaos which characterises the organisation of the average practice…; and if the work of the industrial practitioner were coordinated with that of other medical agencies – then the same volume of work could be handled at a much higher level with due regard to the safety and comfort of the patient."

He further reflects on the effect of the practice environment on the capacity of the practitioners:

> "I found that the working environment of general practitioners in industrial areas was so limiting that their individual capacity as doctors counted for very little".

He concludes:

> "The working conditions…of many general practices are unsatisfactory. Some are bad enough to require condemnation in the public interest".

He suggests:

> "Its [general practice's] defects existed before the National Health Service Act and arise from failure to define general practice and to establish and maintain standards".

He stated two premises which should guide development of general practice:

1. that as many people should be kept out of hospital as possible – whether as inpatients or outpatients;
2. that the medical care of the patient should be integrated not fractionated.

Collings suggested that the three determining factors of the quality of medical care were:

1. the general social environment;
2. the doctor as an individual;
3. the immediate environment in which the doctor works.

He concludes: "Our object will be to change the working environment of the GP and make it possible for him to do better work and to retain instead of discarding the good disciplines of medical school and hospital".

Collings went as far as suggesting some areas for standards development:

1. Separate and private units for consultation and examination for each doctor working in the centre.
2. Adequate personal equipment for each doctor.
3. Such nursing staff as is needed to relieve the doctor of unnecessary and time-consuming tasks.
4. Such clerical staff and office equipment as are needed for proper organisation, running and record-keeping.

Collings' work highlighted for the first time the importance of the working environment in the provision of quality medical care in general practice and suggested some basic requirements for general practice standards.

He further suggested that medical education (refresher) courses, with the conditions of practice as they were, would "do general practitioners about as much good as an injection of adrenaline does a patient with terminal heart-failure".

In a subsequent article in The Lancet, Collings enumerated many of the ideal structural, equipment and organisational attributes of group practice[38] which, had they been taken up at the time, could have been the basis for development of standards for general practices

Some of the organisational principles he suggested were incorporated in subsequent reorganisations of the British NHS.[39]

While Collings' first report concerned British general practice, which he subsequently compared unfavourably with New Zealand general practice,[40] he elucidated basic concepts regarding the relationship between practice structure and function and quality of care which remain valid in most general practice contexts.

While Collings recognised these issues for general practice in the mid 1950s, the effect of the structural and organisational problems in hospitals on the standard of care being delivered had been a subject of interest in the United States for some time. In 1913, at the time of the formation of the American College of Surgeons, a proposal was adopted by the College for a system of 'hospital standardisation' using minimum standards. This system continued to be developed and implemented by the College of Surgeons. It led to the formation of the Joint Commission on Accreditation of Hospitals in 1951.[41] In 1959 similar concerns resulted in the NSW Branch of the Australian Medical Association (AMA) establishing a 'Conjoint Board' to develop a hospital accreditation system in Australia modelled on the United States system. The Board subsequently became the Australian Council on Hospital Standards.[42]

While institutional care was being 'standardised' little attention was being paid to the structure and organisation of private practices. As these were under the individual control of medical practitioners there may have been little incentive (and some resistance) for medical organisations to address this area.

The concept of accreditation of general practices in Australia as a means of improving the delivery of high quality care was first raised during a 'think tank' on the future of general practice convened by Professor Bob Douglas (Director of the National Centre for Epidemiology and Population Health) in Canberra in May 1991 and attended by the candidate.[1] The mechanism of accreditation was perceived as complimentary to the process that had been introduced in 1989 - vocational registration with linked quality assurance and continuing education.[43]

Accreditation was seen as a mechanism for assuring patients of the quality of care delivered by practices. This seemed particularly important in light of other proposals canvassed at the meeting for linkage of patients to practices (eg: creation of patient lists). Many of the proposals which were discussed at that meeting, including that of accreditation, were subsequently incorporated in proposals in the 1991-92 Australian Federal Budget[2] and were developed in a strategic plan negotiated between the Government and the profession in 1992.[4]

Accreditation of health care organisations has a long history in institutional health care, particularly in Australia[42], Canada[44] and the United States.[45] This process is familiar to many Australian clinicians through the work of the Australian Council on Healthcare Standards (ACHS) the sole hospital accrediting body in Australia.[42;46] However the concept of accreditation of general practices was relatively new in Australia in spite of the fact that four decades had passed since Collings so clearly enunciated the relationship between practice standards and the quality of patient care.

The RACGP had already introduced in 1974 an accreditation system for practices in which Family Medicine Programme trainees were to be placed.[24] The accreditation process aimed to ensure that trainees obtained appropriate experience and supervision during there training. However the process was not intended to assess either the clinical competence of practitioners nor the performance of the practice. Similar schemes to accredit teaching practices existed in the United Kingdom[47-49] and New Zealand.[50]

Practice visits to assess the quality of care by individual practitioners for certification, research or educational purposes had also been explored. For example, a research project using a practice visit method was undertaken as early as 1959-60 by Jungfer and Last to assess clinical performance in Australian general practice.[51]

Some 30 years later the Canadian[52], United Kingdom[53] and Australian Colleges[24] introduced assessment processes involving practice visits for Membership/Fellowship or re-certification as an alternative to examination.

A practice visit scheme was developed by the Tasmanian Faculty of the RACGP in 1989 as an educational tool.[54] It drew extensively on the experience of the United Kingdom, New Zealand and Canadian Colleges with similar programs and on the peer review programs developed by Grol et al in the Netherlands.[55;56]

All of these programs were designed to assess and/or educate individual general practitioners though some investigation of practice structure and process was frequently included. Central to these schemes was examination of what Donabedian has called 'technical performance'[57] or the medical aspects of care and the 'interpersonal process'. The assessment process therefore included review of medical records for evidence of appropriate (or inappropriate) care, video taping, audio taping or direct observation of consultations.

The difficulties of separating practice from practitioner were recognised by Schofield et al in the RCGP Report 'What Sort of Doctor'[58] in 1985. The RCGP policy document 'Quality in General Practice' later the same year pointed out that "in many circumstances the functional unit of care is the practice rather than any individual or professional group".[59]

Over the same period similar initiatives had occurred within community health in Australia. In 1983 the Australian Community Health Association (ACHA) [60] took the first steps towards the development of an accreditation scheme for community health centres. After initial development in New South Wales a National 'Manual of Standards for Community Health' was produced in 1985[61] by the Community

Health Accreditation and Standards Program (CHASP).[62] The standards are now used in a voluntary accreditation system for community health centres. The CHASP standards were conceptualised as 'ideals' rather than minimum standards. Fry reported that some general practitioners working in community health centres in South Australia, Victoria, Tasmania and the ACT had taken part in CHASP reviews.[3] The CHASP program has attempted to combine the assessment of centre or service with that of practitioner.

By 1992 the accreditation proposals in the Federal budget of 1991 were generating considerable discussion. Bollen, Miller (the candidate) and O'Halloran writing during negotiations between the profession and the Australian Government regarding the implementation of accreditation of general practices defined accreditation as 'a process whereby an individual or organisation is formally recognised as meeting certain defined requirements and/or standards'.[3] This definition adds a regulatory dimension to the discussion and moves the concept towards a process of summative assessment.

Accreditation can be a method for ensuring accountability for compliance with minimum standards. Alternatively it can be a process for introducing continuous quality improvement to an organisation and setting goals for achievement. These two processes are not mutually exclusive although they may at times conflict if the compliance requirements attract the major incentives and therefore the attention of practices.

The ACHS hospital accreditation process, discussed earlier, was for many years one of assessment against minimum standards that were focussed on organisational issues and safety. With the 'EQuIP' program the ACHS has moved towards a quality improvement model as the basis for accreditation.[63]

Bollen, Miller and O'Halloran also set out performance areas which could form the basis for a set of standards on which accreditation may be based.[3] Early in 1992 Harris et al[64] and Strasser[65] produced 'model practice standards' for the Commonwealth Department of Health, Housing and Community Services.

Later in 1992 negotiations took place between the RACGP, the AMA and Government to review the Governments proposals contained in the 1991 Budget Papers. The process resulted in the publication of a joint document called '*The Future of General Practice: A Strategy for the Nineties and Beyond*'.[4] This document outlined principles upon which a general practice accreditation system could be based.

As earlier stated by Collings, even highly skilled practitioners cannot function effectively in circumstances where physical, organisational or attitudinal factors inhibit the delivery of high quality care. Practice accreditation seeks to measure the extent to which practices facilitate the delivery of high quality of care by clinicians to their patients. This process compliments other quality initiatives which seek to improve the knowledge, skills and attitudes of individual clinicians.

An effective accreditation scheme should also provide a reliable certification to patients and funders of the quality of care delivered to the practice population.

Principles of accreditation

During discussions between the profession and government several principles were espoused to guide the development of accreditation in general practice in Australia. These were published by the Department of Health, Housing, Local Government and Community Services in 1993.[66]

The principles were stated as follows:

1. The development of standards for accreditation is a professional activity which is rightly the responsibility of GPs.
2. Standards should be credible and achievable.
3. An accreditation system needs to balance the competing interests of the need to recognise and encourage the diversity of general practice with the need for a nationally uniform system of standards.
4. Accreditation should be voluntary but should also provide tangible benefits.

5. Accreditation should assist in developing individual practices as well as general practice as a discipline.
6. The process of accrediting practices should be controlled by GPs.
7. The accreditation system should allow broad input from a range of interests.
8. accreditation should provide a publicly recognisable measure of commitment to quality care.
9. Accreditation should encourage and assist general practice to meet the challenges presented by changes within the health system.
10. The accreditation process should be independent of established interests.

The process of developing accreditation was stated as coming in three phases:

- the development of the content of accreditation including the development of standards, the testing of standards and the trialing of potential assessment methods;
- the development of the process. In other words who or what will run an accreditation process and how should it be funded; and
- a review of the outcomes of accreditation including: what tangible benefits have accrued to general practitioners; whether market advantages to accredited practices had resulted; and what if any were the benefits to patients.

Development and testing of standards

As part of its role as the organisation recognised by the government as the 'arbiter of standards' in general practice and the developer of educational programs, the RACGP in 1992 agreed to undertake the development and testing of standards.

CHAPTER 3

DEVELOPMENT OF STANDARDS FOR ACCREDITATION

The development of a set of standards is an essential prerequisite to the implementation of an accreditation system.

The Australian government in conjunction with the profession (and the involvement of the candidate) developed and published 'Principles for establishing an accreditation system' in conjunction with general practice organisations. The first two principles cover the development of standards and were the basis on which standards were subsequently developed. The published principles are set out below:

1. **The development of standards is a professional activity which is rightly the responsibility of GPs.**

   "Standards development can only be done by the profession itself. In line with this principle, funding has been provided to the RACGP to develop standards for general practice."

2. **Standards should be credible and achievable.**

   "This principle underscores the need for quality in an accreditation system but also the need for both realistic expectations and widespread participation of the profession if accreditation is to achieve its aims. Thus standards which are developed need not only to be credible to general practice but also to other interested parties including other health professionals and consumers. To achieve this the RACGP has embarked on a process of wide consultation. Being achievable is also an important element of being credible, Understandably the profession would want to set itself high standards. Through high standards it can indicate its commitment to quality to both the public and individual GPs. However, it is also important that these standards are achievable so that practices are encouraged to participate, not discouraged through fear of failure."[66]

In October 1992 the RACGP received a preliminary grant from the then Department of Health, Housing and Community Services to develop standards for accrediting general practices.

The purpose of the initial grant was:

> "To develop interim standards for accreditation of general practices and to prepare a proposal for development of entry and optimal standards for accreditation of general practices."

The Standards Working Party (SWP) was formed in November 1992 with the goal of developing a set of practice standards. The working party comprised GP academics and general practitioners from rural and urban practices, all of whom had wide general practice experience. The candidate was a foundation member of the SWP.

The RACGP established a Standards Development Unit (SDU) to assist the Standards Working Party with the development of the standards.

Early in the process the Standards Working Party decided to divide the development of standards into two phases:

- the development of entry standards designed to determine whether minimum levels of quality have been achieved by practices. The entry level was conceived as a starting point for a process of continuing quality improvement by general practices;
- the development of optimum standards which would set ideals towards which practices could aim in order to facilitate the continuing quality improvement process.

A review was undertaken of standard setting processes in health in Australia and overseas.

Bollen, Miller (the candidate) and O'Halloran had outlined possible content areas for consideration in developing standards.[3] Harris et al had devised a set of model standards for general practice in a consultancy for the Commonwealth government.[64] Dr John Bampton, Chair of the Vocational Training Accreditation Committee of the RACGP, had also developed criteria for accreditation of practices.[67]

These three papers together with material from the review were the starting point to develop content areas for standards and within these areas, the standards themselves.

A detailed literature review of patient perceptions of general practice quality was undertaken by the Standards Development Unit. Information from the review was incorporated into the draft standards.[68]

The content framework for the standards was developed as a synthesis of the content areas derived from eight documents: the Community Health Accreditation and Standards Project (CHASP) Manual of Standards for Community Health[69], the Royal College of General Practitioners (RCGP) publication 'What sort of doctor'[58], the RACGP Tasmania inter-practice visit program protocol[55], the Royal New Zealand College of General Practitioners (RNZCGP) Quality Assurance Programme Reference Manual[70], the Australian Council on Healthcare Standards (ACHS) Accreditation Guide[71], the National Centre for Epidemiology and Population Health (NCEPH) paper by Bollen et al[3], the consultancy report "Model Standards for General Practice' by Harris et al[72] and a report to the RACGP titled 'Accreditation of General Practice' developed by Dr John Bampton, chairman of the RACGP Vocational Training Accreditation Committee.[67]

Within this content framework, individual standards items were selected by the SDU Research Officer from the above documents and from the RACGP 'Standards required of family practice teaching posts'.[73] Standards were selected on the basis of frequency of occurrence in multiple standards documents and on their appropriateness as standards for general practices. The selected standards were incorporated into a working document for the ISWP. The standards in that document, ISWP Background Paper 2, were assessed by the ISWP members both individually and collectively. Individual items were judged acceptable as is or with simple rewording, returned to the SDU for further research, and/or further consultation, or were rejected.

After several iterations of review by the ISWP, Draft Interim Standards for General Practice[74] evolved and 170 copies were distributed widely for comment in January 1993. The mailing list included peak bodies such as the Australian Medical Association and the Australian Council on Healthcare Standards, consumer groups, academics, vocational registration committees and RACGP faculties, sub-faculties and committees. Sixty two replies were received to the invitation to comment on the draft, an overall response rate of 36.5%.

The responses were collated by the SDU and compiled with comments into ISWP Background Paper 4.[75] All the items were again reviewed by the ISWP in the light of comments. This review process also reflected the decision taken by the ISWP at this time to develop minimum standards rather than optimum standards. As a result many individual standards were modified, some extensively, and some were deleted.

The ISWP suggested that a criteria for success in setting minimum standards was that they would be met by at least 85% of general practices.

The revised Draft Interim Standards were published as the Draft Standards for General Practice in March 1993. The revised draft introduced footnotes to the standards referencing evidence from the literature supporting their inclusion.

The first Draft Standards were distributed widely within the RACGP and to a number of peak bodies, including the AMA, the RDAA, consumer groups, Divisions of General Practice and over 300 general practitioners. As a result of the feedback obtained on the first draft[75], a second draft was prepared.

The second draft, released in April 1993, was once again circulated within the RACGP and sent to peak bodies. Through a series of articles in *Australian Doctor*, a weekly newspaper distributed to all GPs, the standards were also made available to interested general practitioners Australia-wide. Over 600 copies of the standards were distributed for comment.

The SWP received over 100 written submissions on the document throughout May and June of 1993. The standards were then thoroughly reworked, incorporating many of the ideas and concerns contained in the submissions.[76]

A third draft was then prepared. This draft was not publicly 'released' and was distributed only to practices and individuals involved in the pilot test.

In September, October and November the draft standards were pilot tested in 25 volunteer practices across Australia. This was achieved with the assistance of several Divisions of General Practice, Faculties of the RACGP and state Rural Doctors Associations. Each practices was visited by two surveyors - one a member of the Standards Working Party (being the candidate on five occasions) and the other a local GP. Of the 25 practices visited approximately half were rural while one third were solo practices.

The pilot visits had a number of specific objectives:

- to gain an understanding of how the standards might be applied and assessed in a practice setting;
- to test the standards against reality and suggest possible changes;
- to identify possible indicators, or ways of measuring the criteria;
- to develop a draft visit protocol for assessing the standards; and
- to test the face validity of the standards and ensure that they are both comprehensive and appropriate.

After the completion of the first five practice visits 130 indicators were added to the draft entry standards which were used for assessment in the subsequent pilot visits.

On 17 November 1993 (towards the end of the pilot program) the SWP held a Standards Assessment Workshop to review various aspects of the standards and the assessment process being used in the pilot visits. A 'Draft Visit Protocol' was developed for use and refinement in subsequent pilot visits.

The SWP met for two days (8-9 December 1993) to review the results of the pilot program and re-write the entry standards document. Further indicators were incorporated into the document and many criteria were changed based the experience gained from the pilot visits.

The resulting document was titled 'Entry Standards for General Practice - Draft for Field Test and Demonstration Trials'. (see Appendix 1)

The 'Assessment Protocol' was further developed for assessing the Entry Standards in practices. This protocol was a step by step guide for surveyors assessing the standards on practice visit. (see Appendix 10)

The pilot demonstrated the need for a more rigorous examination of the standards in a representative sample of practices across Australia.

In January 1994 the candidate was appointed Director of the RACGP Standards Development Unit and subsequently, in March 1994, the Department of Human Services and Health provided the RACGP with a grant to undertake nation wide testing of the standards.

CHAPTER 4

METHOD

4.1 Aim and objectives of the Field Test

Aims: To provide data that will help ensure that the standards will be acceptable to the majority of general practitioners; and

to ensure that the standards are fair and do not discriminate against particular types of practices (eg solo or rural practices); and

to further evaluate the method of assessment developed during the pilot program.

Specifically the Field Test sought to test the validity, reliability, acceptability and achievability of the standards and the feasibility of using the standards and assessment processes in an accreditation system. The feasibility aspect of the Field Test is not addressed in this thesis.

4.2 Research questions:

Do the standards reflect good general practice? (face validity)

Do the standards cover all aspects of good general practice? (content validity)

Do the standards reflect some other measure of good general practice? (criterion validity)

Are the standards acceptable to general practices?

Are the standards achievable by general practices?

How many practices would be accredited against the standards in an accreditation system? (the Standards Working Party had designed the Entry Standards as minimum standards and proposed the hypothesis that 85% of practices would meet the standards)

Do the standards discriminate against different types of practice?

Are the standards a reliable measure of general practice quality?

4.3 Research design

The broad design of the Field Test was developed by the Standards Working Party and agreed at a Field Testing Workshop held on 9 December 1993. Input was obtained from representatives of the Department of Human Services and Health, research methodologists and statisticians including Dr Dan Tyson, KPMG Peat Marwick; Dr Helena Britt, Director, Family Medicine Research Unit; Ms Linda Kehoe, statistician, Total Research; and Associate Professor Andrea Mant, Chairman, Research Committee of Council, RACGP. The workshop was convened by the Standards Working Party to develop a consensus on the research design of the Field Test within the constraints set by time and resources.

The broad outline was further developed, refined and operationalised by the Standards Development Project team under the direction of the candidate.

This chapter sets out the operational and analytical methodology used in the Field Test of the Entry Standards.

The design of the Field Test was dictated by the need to test the real life processes that might be used in an accreditation system in addition to testing the RACGP Entry Standards for General Practice. The Field Test therefore mimicked the peer review accreditation method proposed by the RACGP.

The Field Test consisted of the following processes:

1. selection and recruitment of a sample of general practices through a stratified random sample of general practitioners from all over Australia;
2. selection and training of a group of general practitioners to act as peer surveyors of the selected practices using the assessment protocol developed as a result of the pilot surveys;
3. collection of demographic data from the contact doctor in participating practices, and from the sample doctor in refusing practices, to allow comparison between the two groups and with the whole defined general practitioner population;
4. collection of demographic data from surveyors to facilitate matching the characteristics of the surveyors to practices they visited;
5. collection of data on patients' assessment of the quality of aspects of the practice through an optional patient survey, to assist surveyors in the assessment process;
6. self assessment by each practice of their compliance with the Entry Standards through completion of a structured, paper based self assessment form;
7. conduct of practice visits by two surveyors to each practice using a protocol to assist consistent assessment of practice compliance with the Entry Standards;
8. completion of 'global assessment' by the surveyors of the quality of each practice;
9. preparation of practice reports by the surveyors which were then edited by the project team and returned to the practices;
10. completion of questionnaires by each practice after their practice assessment and by each surveyor after completion of the Field Test to obtain feedback on the Entry Standards and the assessment process;
11. conduct of surveyor workshops after the Field Test to obtain feedback on the Entry Standards and the assessment process and to assist in the review of the Entry Standards and the assessment process;
12. data analysis and reporting.

Each of these processes is described in more detail below.

4.4 Detailed method

4.4.1. Selection and recruitment of general practices.

The purpose of the Field Test was to examine practice (rather than individual practitioner) compliance with standards. While there is a register of recognised general practitioners in Australia there is no national register of practices. The only effective way of identifying and recruiting practices was therefore through individual practitioners.

To fulfil the aim of the Field Test to determine that the Standards applied equally to practices of different sizes and to both metropolitan and rural practices it was necessary to stratify the sample to ensure adequate numbers of remote and small practices for analysis. A pure random sample would have been unlikely to yield a sample of rural and remote practices of sufficient size for analysis. Furthermore, stratifying for 'rurality' was likely to have the effect of reducing selection bias towards group practices inherent in the process of using individual practitioners to select practices. This was because there is a larger proportion of small practices in the non urban rural and remote areas in Australia.

It had been determined by statistical consultation with Mr Geoffrey Sayer of the Family Medicine Research Unit, University of Sydney, using Epi Info,[77] and consensus at the Field Test workshop that a total sample of 200 practices would be adequate to allow stratification for 'rurality' and practice size and would be logistically and financially feasible. It was also determined that a stratified random national sample of practices would provide a statistically representative group for the purpose of data analysis.

The sample was therefore stratified according to the Rural/Remote Areas (RARA) classification of the Department of Human Services and Health.[78]

The seven RARA classes are as follows:-

1. Capital City
2. Other Major Urban
3. Rural Major
4. Rural Other
5. Remote Major
6. Remote Other
7. Other Offshore Areas.

RARA 7 was excluded for logistic reasons (cost and probable distance). It should be noted that RARA 7 comprises less than 0.05% of the Australian population and includes places such as Christmas Island.

Owing to sample size restrictions (see above) the sample was stratified into three composite RARA groups -

RARA 1 and 2; Capital city and other major urban

RARA 3 and 5; Rural major and Remote major

RARA 4 and 6. Rural other and Remote other

This was done following consultation with rural practitioners and as a result of prior research suggesting that significant differences were more likely to emerge when rural and remote areas of similar urban population density are grouped together.[79] Statistical modelling using Epi Info led to a determination to recruit 100 practices from RARA 1/2, 50 practices from RARA 3/5 and 50 practices from RARA 4/6.

Sample frame

The RACGP Quality Assurance and Continuing Education Program holds a database of all general practitioners in Australia who:-

- are currently listed as registered or eligible for registration on the vocational register (or were at some time listed on the vocational register); and/or
- have at some time applied to be on the vocational register; and/or
- are members or ex-members of the RACGP; and/or
- are registrars in the RACGP Training Program.

In January 1994 this database contained approximately 23,000 entries. From this database a sample set was derived comprising 'recognised' general practitioners as described in the Medicare Benefits Schedule.[80] ie:

"a General Practitioner is a medical practitioner who is:

Vocationally Registered under Section 3F of the Health Insurance Act;[81] or

a holder of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participates in, and meets the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Program.[33] or

undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP, or undertaking an approved placement in general practice as part of some other training program recognised by the RACGP as being of equivalent standard."

From this sample, the following general practitioners were excluded:-

- those listed as eligible for recognition but who were inactive because they were temporarily absent from general practice or not predominantly in general practice;
- registrars in the RACGP Training Program (as they are without a permanent identifiable practice);
- Honorary Fellows of the RACGP who were not on the Vocational Register.

The resulting sub-sample comprised 15,384 general practitioners.

Using a list of postcodes in each RARA, each practitioner in the sample frame was assigned to one of the three strata on the basis of their preferred mailing address, this being the only address held on the RACGP database. This resulted in 11,878 GPs being allocated to RARA 1/2, 1,858 to RARA 3/5 and 1,555 to RARA 4/6. Another 93 practitioners were excluded from the sample as there was no match for their postcode in the postcode/RARA list supplied by the Department of Human Services and Health.

Using an algorithm developed by the Family Medicine Research Unit, University of Sydney, each stratum was then subject to a process of randomisation. To save computer time the randomisation of RARA 1/2 was halted when 10 times the required sample had been randomised.

The first 100 in the RARA 1/2 randomised list, the first 50 in RARA 3/5 and the first 50 in RARA 4/6 made up the initial sample of 200 general practitioners to be approached.

Practice recruitment

Each GP in the initial sample was sent a letter from the President of the RACGP seeking the participation of their practice in the Field Test (Appendix 2) and a copy of the *Draft Entry Standards for General Practice* (Appendix 1).

Sample doctors were then contacted by telephone. The first phone call was made two weeks after letters had been sent. Phone calls were made using a formal protocol. The purpose of the first call was to ensure that the letter and accompanying information had been received and understood and to determine if the sample doctor wished to continue as the contact for the practice. While many practices agreed to participate at this time, some required more time for the contact doctor to discuss the Field Test with others in their practice.

Practices which agreed to participate were sent a letter of instructions (Appendix 3) together with a copy of the *Draft Entry Standards for General Practice* (Appendix 1) to use for self assessment and a copy for each doctor in the practice, instructions for self assessment (Appendix 4). information sheets about the practice visit (Appendix 5) and a practice quality assurance points form (Appendix 6) to allow them to claim 20 practice assessment points for each doctor offered by the RACGP QA program for participation in the Field Test.

In two instances practices were inadvertently recruited through sample doctors in a different RARA group. This occurred as a result of the sample doctor's preferred address being in a different RARA group to their practice address. While policy was generally to exclude such practices (as occurred in the case of one locum) the decision was made to retain these two because visits had already been organised. They were then replaced with the next practice in the randomised list from their original RARA group. It should be noted that as a result the RARA characteristics of agreeing sample doctors differ slightly from RARA characteristics of participating practices.

At the time of telephone contact sample doctors were excluded from the sample if they:

(i) had retired from general practice;

(ii) were on leave and would not be returning within one month;

(iii) were locums who could not suggest a practice within their RARA group;

(iv) were not currently in general practice;

(v) could not be contacted;

(vi) had some prior involvement in the standards development project (eg they had participated in the piloting of standards, had a surveyor in their practice or were the second sample doctor in a practice);

(vii) had received a letter late in the period of recruitment and became due for a phone call after the quota of practices had been filled.

Sample doctors who refused to participate were asked the reason for refusal and for demographic data to allow comparison with participating doctors.

Sample doctors who refused to participate or who were excluded were replaced by the next sample doctor within their RARA grouping until each stratum was filled.

4.4.2. Surveyor selection, recruitment and training

Surveyor selection

With the exception of being a member of the population already defined for the selection of practitioners for practice recruitment there were no formal qualifications required of surveyors.

Logistic considerations determined the number of surveyors to be recruited. Two surveyors were required for each practice visit and a balance of metropolitan and rural practitioners were needed to provide matching between surveyor and practice for practice size and 'rurality'. It was calculated that 77 surveyors across the country would be sufficient to conduct the Field Test in the required time frame.

Surveyors were selected by RARA (although the selection criteria comprised two groups, RARA 1/2 and RARA 3 to 6 rather than the three groups for practices) and state to match the proportions of the recruited general practices. It should be noted that surveyors were not intended to be a representative group. Surveyors were selected on the basis of peer recommendations.

While the surveyor selection process did not utilise a randomised sample of general practitioners, there was no reason to believe that the selection process produced a group which differed from the volunteer practice contact doctors and the other doctors in those practices in any systematic fashion.

Surveyor recruitment

The required 77 surveyors were recruited through informal networks including the RACGP, Divisions of General Practice and the Rural Doctors Association of Australia.

The surveyors were volunteers recruited from a 'convenience sample' of GPs supplied by the organisations listed above. Most had previous involvement with educational or training activities. Some also had experience with accreditation of RACGP training practices. Surveyors were asked to commit themselves to at least three practice visits and to attend a surveyor training session. Volunteers were accepted for each stratum until that stratum was full. Surveyors were older, more frequently male and more frequently from larger practices than practice contact doctors. This probably reflected the greater time availability of practitioners with these attributes.

This process mimicked the recruitment method which might be used in an accreditation scheme.

Surveyor training

The purpose of surveyor training was to familiarise the surveyors with the theory and practice of accreditation in order to ensure high levels of reliability and fairness in the process of the Field Test.

The objectives of the training were:

- "To familiarise surveyors with the basis for the development of standards and their role in health care;

- To clarify any surveyor concerns regarding the standards and their interpretation;
- To encourage a consistency of approach to assessment by surveyors by the use of training scenarios, simulations and role plays of various aspects of the assessment process;
- To provide detailed instruction on the administrative aspects of the Field Test"

The training program was developed by Professor Richard Hays of the North Queensland Clinical School, University of Queensland. Professor Hays, also a member of the Standards Working Party, conducted the first workshop in Sydney and a second in Townsville.

The remainder of the training workshops were conducted by a training consultancy from the School of Medical Education at the University of New South Wales (Dr Phillip Godwin, Dr Arie Rotem and Dr Jeanette Ward). Dr Philip Godwin attended the first workshop to learn the facilitation process for the workshops under the supervision of Professor Hays. Dr Godwin facilitated all of the subsequent workshops with the exception of the Townsville workshop conducted by Professor Hays. This ensured a consistent approach to surveyor training across all the States.

Standards Development Project staff recruited surveyors and organised logistics (eg travel, accommodation, venues etc) for each of the workshops. The candidate attended all training workshops to provide expert opinion regarding interpretation of the Standards and Criteria and to assist with training.

Standards Development Unit staff also attended all workshops to provide a consistent message regarding organisation and conduct of the Field Test.

Surveyor training was divided into three parts - a training day, a mock visit and a teleconference.

All surveyors were required to attend a one day training session before they began their practice visits. Surveyors were given pre reading materials and homework for completion before attendance at a workshop. The purpose of these workshops was to familiarise the surveyors with the standards document and the protocol for undertaking Field Test visits and to train them in the process of assessment.

Surveyor training began in Sydney on 9 March 1994. Subsequent training workshops were held during March and April in Melbourne, Adelaide, Sydney, Townsville and Perth. An additional workshop was held on 9 June in Adelaide to supplement surveyor numbers (Table 4.1).

Table 4.1 Surveyor training workshops

Date	Location	Surveyors trained
9 March 1994	Sydney	23
23 March 1994	Melbourne	17
24 March 1994	Adelaide	7
30 March 1994	Brisbane	10
7 April 1994	Townsville	5
20 April 1994	Perth	8
9 June 1994	Adelaide	7
Total		77

This workshop was then followed by a `mock visit' where the surveyors practiced going through the protocol at, in most instances, another surveyors practice. The mock visits allowed surveyors to familiarise themselves with the process in a practical setting.

After the mock visit had taken place, teleconferences were conducted in each state in order to allow the surveyors an opportunity to ask questions and discuss their experiences in the mock visit before attending their first Field Test visit.

Surveyors were asked to rate the usefulness of the surveyor training workshop on a scale with a range of 1 to 5 to choose from, with 1 being not useful to 5 being very useful. The mean score was 4.00. Over 80% of surveyors rated the training as useful or very useful.

Many surveyors commented that whilst the training workshop was useful, the subsequent Field Test visits themselves provided the greatest source of learning about the standards and assessing a practice.

> *"The workshop was helpful because it gave us an opportunity to talk through everything, but the first and second visits taught us a whole lot more."* (Surveyor, Vic)

Perhaps because of its practical approach surveyors commented that the mock visit was particularly useful for teaching and preparing surveyors to visit practices:-

> *"I found the mock visit to be extremely useful and think that probably two visits (mock) would be reasonable if, for example, practice enhancement grants were dependent on practice assessment."* (Surveyor, SA)

Whilst surveyors generally found the training to be useful, the workshops were not without critics, for example:-

> *"The workshop attempted to standardise everyone's ideas and opinions."* (Surveyor, QLD)
>
> *"There was not enough explanation about the indicators and why particular ones were chosen."* (Surveyor, QLD)
>
> *"It was useful as an introduction to Entry Standards but probably not worth the effort and cost. The workshop could have been replaced by a succinct letter or brochure."* (Surveyor, NSW)

Despite these comments, the general consensus was that the workshop was a valuable introduction to practice visiting and acceptance that some formal training is a necessary part of the process.

From the comments received there seems to be little disagreement that training workshops must include a practical component such as the mock visit:-

> *"The workshop reinforced that a balance view needed to be adopted when assessing practices and reminded us of our own biases."* (Surveyor, QLD)
>
> *"I would have found it difficult to have been as objective without the workshop."* (Surveyor, NSW)
>
> *"I could not have done the visit without the workshop"* (Surveyor, SA)
>
> *"The workshop was essential." (Surveyor, WA).*

4.4.3. Practice demographic data collection

Practices were sent a questionnaire to gather demographic data to compare the practitioners in participating practices with practitioners who refused to participate and with the rest of the defined general practitioner population (Appendix 8).

Practitioners who refused to participate were asked for demographic data by phone.

4.4.4. Surveyor demographic data collection

Surveyors were asked to complete a questionnaire (Appendix 9). The data collected was designed to facilitate matching of surveyors to practices in terms of 'rurality' and practice size.

4.4.5. Patient survey

One of the process objectives of the Field Test was to assess the feasibility of including in the practice assessment by surveyors information from a survey of patient assessment of practice quality. A number of indicators requiring patient feedback were included in the standards document where patient assessment of compliance was appropriate.

Neither time nor resources permitted the development of a specifically designed instrument. The patient survey (Patient Participation Programme) offered in the RACGP Quality Assurance and Continuing Education Program by the RACGP Research and Health Promotion Unit in South Australia (hereafter called the 'Unit') was therefore adopted (Appendix 7). This survey instrument had been developed and validated by Dr. Ian Steven, Director of the Unit.[82;83] It was designed to enable patients to give feedback about how well their needs were met by the practice. The survey covers issues of accessibility, structure, availability, preventive care and the doctors' attitudes and communication skills. It was thought that the survey would provide data for the surveyors in the areas in the standards covered by the survey.

Practices agreeing to participate in the Field Test were offered the option of undertaking the patient survey. Just over three quarters (75.9%) of participating practices agreed. When practices agreed to do the survey Standards Development Project staff notified the Unit which then dispatched the survey forms to the practice.

In line with the usual process applied in this established patient survey, practices with 2 doctors or less were sent 100 questionnaires, practices with 3 to 5 doctors were sent 200 questionnaires and practices with 6 to 9 doctors were sent 300 questionnaires.

Practices were provided with the standard Unit instructions for the survey, special instructions for the Field Test and clearly marked pre-paid envelopes to be used when returning completed questionnaires for processing. The survey data was analysed by the Unit in South Australia. Survey results were confidential to practices however they were made available by the practices to surveyors for assessment at the practice visit.

The Unit advised that the survey could be administered to patients and then processed within two to three weeks. Despite the tight time constraints under which the Field Test was conducted, it was decided to maximise available time by ensuring that, for practices doing the patient survey, a minimum of four to five weeks was available between recruitment and practice visit. The average time between recruitment and practice visit was 7 weeks and 2 days.

4.4.6. Self assessment

Practices were asked to assess their own practices using the same instrument (included in the Entry Standards document - Appendix 1) as the surveyors used for independent assessment. A set of instructions (Appendix 4) was given to each practice to facilitate completion of the assessment. Practices were requested to complete the self assessment before the surveyor visit.

4.4.7. Practice visits

Each practice involved in the Field Test was visited by two surveyors. As far as possible surveyors were matched to the practice for 'rurality' and practice size. The candidate or another member of the Standards Development Project staff acted as an observer at 13% of visits. The surveyors used an Assessment Protocol (Appendix 10) to conduct the practice visits.

Practice visits began on 23 April 1994 and ended on 31 August 1994 (Table 4.2).

Table 4.2 Practice visit schedule

Month (1994)	April	May	June	July	August	Total
Number of visits	1	21	58	72	47	199

Each practice visit was conducted in three stages - interview, observation and assessment. The first two stages involved data collection, while the third involved analysis of the data and assessment of the practice.

The first stage (interview) provided the two main sources of data about the practice:

(i) *Doctor interview(s)*: an interview with the principal GP in the practice. This interview, taking about an hour, covered assessment of practice compliance with all aspects of the standards. Other doctors, if any, were then interviewed, usually for about 15 minutes each. These shorter interviews concentrated on specific aspects of the standards.

(ii) *Staff interview(s)*: a selection of staff in the practice were interviewed. In practices with only one support staff the interview lasted 20-25 minutes. In larger practices, where staff tend to specialise, shorter interviews of 5-10 minutes were held with multiple staff such as receptionists, practice managers and nurses.

The second stage of the visit, practice observation, involved collection of data from five sources:

(i) *Medical records review*: an examination of 20-25 medical records, chosen at random.

(ii) *Appointments schedule review*: an examination of the practice's appointments schedule.

(iii) *Documents and other records*: an examination of any other practice-held records and documents that may assist in the assessment of indicators, eg copies of referral letters, staff manuals etc.

(iv) *Direct observation*: general observation of the practice, its facilities and equipment.

(v) *Patient survey results*: examination of patient survey results (where available).

During the third stage of the visit (assessment) the surveyors were required to judge the extent to which the practice met each criterion. The categories available were:

Substantial - sufficient indicators have been met and that criterion has been met

Partial - certain aspects of the criterion have not been met

Nil - the criterion has not been met

Not Applicable - the criterion is not applicable to that practice, (for example it may refer to a group practice only).

Surveyors and practices marked or circled the appropriate responses and returned the completed forms to the project office. When errors or omissions were identified by the project staff questionnaires were returned to the surveyor or practice for correction.

Surveyors were asked specifically not to rank the practices on individual standards. A score of whether practices would have 'met' or 'not met' the standards was determined by reviewing the score for each essential criteria within the standard. Where a practice scored 'nil' for any essential criterion within a standard they were deemed not to have met that standard. Where there were missing data for individual criteria, unless all data were missing, the practice was deemed to have passed that standard. To 'pass' assessment practices were required to meet all of the standards.

The surveyors completed several assessment forms in the practice:

(i) Independent assessment

Each surveyor *independently* assessed the practice using a copy of the standards and the data collected in the Assessment Protocol (Appendix 10). In order to assess which indicators were used by the surveyors to assess compliance with a criterion, surveyors were asked to tick indicators met by the practice. Surveyors were instructed *not to change* their individual assessment once it had been completed. The principal surveyor then collected both independent assessments for later mailing to the Standards Development Project.

(ii) Joint assessment

After completion of their individual assessments the surveyors discussed their findings and agreed on a joint assessment for each criterion. This was recorded on the Joint Assessment sheet (Appendix 11).

4.4.8. Global assessment

Surveyors were asked to agree on a joint global assessment of the practice. This was provided in response to the question "If this assessment had been a formal accreditation visit, do you think this practice should have been accredited or should not have been accredited?".

It was emphasised to surveyors that their answer to the above question should be based on a subjective assessment as to whether it would be fair, in their opinion as peers, to 'accredit' the practice regardless of its performance on the Entry Standards, that is regardless of whether all essential criteria were met.

4.4.9. Surveyor visit reports

Verbal practice report

At the conclusion of each visit the surveyors presented brief verbal reports to the practices on their performance.

Surveyor written report

Immediately following each visit the principal surveyor prepared a written report on the visit for the practice (Appendix 12). Final reports, comprising surveyors joint assessment of each criterion and written reports, were edited (to ensure they did not contain material which could be seen as offensive or libellous by the practice) and collated by Standards Development Project staff before being sent to the practices accompanied by a final letter from the candidate thanking them for their participation (Appendix 14).

Surveyor questionnaire

Surveyors also completed a one page questionnaire (Appendix 13) which covered basic logistic issues such as time spent on the visit but also provided an opportunity to record any difficulties or special circumstances encountered during the visit.

4.4.10. Practice post visit questionnaire and surveyor post Field Test questionnaire

Each final practice report was accompanied by a questionnaire (Appendix 15) which was designed to obtain both qualitative and quantitative data about the practice's view of the process of the visits and the content of the standards.

Surveyors were sent a similar questionnaire when they had completed their allocated visits. This questionnaire was designed to assess the process and standards from the surveyor's viewpoint. The questionnaire collected both quantitative and qualitative data. A Lickert scale was used to gain information on usefulness of various aspects of the Field Test (Appendix 16).

4.4.11 Surveyor workshops

During March and April 1995, the Standards Development Unit conducted six workshops with surveyors to review the Entry Standards and the methodologies employed to assess them.[84]

The workshops followed a focus group model in which surveyors were encouraged to talk freely and spontaneously about a variety of topics relating to the Entry Standards and their assessment.

The surveyor workshops were held across Australia (Sydney, Melbourne, Brisbane, Townsville, Adelaide and Perth). Workshops began in Sydney on 16 March 1995 and concluded in Townsville on 6 April 1995.

The workshops involved selected surveyors from both the Field Test and the Demonstration Trials and were conducted jointly by both research teams. Surveyors who had undertaken the largest numbers of practice visits were invited to attend.

The one day workshops commenced at 9.30 am and concluded at 4.30 pm. They were structured into five sessions.

Session one, presented by the candidate, gave a general view of the results of the Field Test and the Demonstration Trials.

Session two consisted of a review of the standards to formulate recommendations for the Standards Reference Group. Participants were asked to agree on a list of criteria and indicators to be reviewed, to review the selected criteria and indicators and to suggest improvements where appropriate. The

surveyors were also asked to comment on those standards and criteria that had been rewritten by the Standards Reference Group following the results of the Field Test.

Session three: The surveyors were then separated into two groups, the Field Test surveyors and the Demonstration Trial surveyors. The groups separately discussed the protocol used in their project. They were asked to provide detailed suggestions to assist in redesign of the assessment protocols, to assess the usefulness of different components of the visit and to assist in the design of an "ideal" surveyor training program.

Session four sought to achieve a consensus view of visit style and the composition of visit teams and to reach consensus on the most useful types of measurement scales.

Finally session five consisted of an open discussion session which covered any issues which the surveyors wished to raise that had not been addressed in previous sessions. This session was facilitated by the candidate and the Senior Research Officer.

In all, 41 of the 65 criteria were reviewed in at least one of the six workshops (12 criteria were reviewed in all six workshops). Written notes of the Field test discussion were taken by SDU staff for later collation. Notes taken by SDU staff from all six workshops were collated by the Senior Research Officer and reviewed by the candidate. No formal scientific analysis was undertaken of these qualitative data.

Recommendations and comments on these criteria in the workshops may be found under individual criteria in Chapter 5, section 5.4 of this thesis.

4.4.12. Data analysis and reporting

Introduction

The main purpose of the Field Test of entry standards for general practice was to test the reliability, validity and acceptability of the standards. Analytical methods applied to the quantitative and qualitative data were largely determined by this aim.

For each practice visited there were four measures of the standards (self assessment, joint surveyor assessment, principal surveyors assessment and second surveyors assessment). Each practice was also assessed by 'global assessment' as described above. Practice post visit questionnaires and surveyor post Field Test questionnaires were also used to elicit opinion on criteria, standards and the survey process.

Quantitative data

Quantitative data obtained from the Field Test were predominantly categorical.

All quantitative data were entered in a customised data base program using Paradox software, on networked personal computer hardware. All data were checked for errors by a second data entry operator. This was done by the second data entry operator checking every data element entered by the first operator against the original source documents. Forms with missing or illegible data were returned to surveyors and practices for completion or clarification. All analyses were performed using SPSS 6.1.[85]

Qualitative data

Qualitative data relating to certain parts of the Field Test were also collected. These required surveyors, practices and observers to state their view of the standards, criteria and process of the Field Test.

These qualitative data were collected to guide the subsequent development of the Entry Standards and the accreditation process, neither of which are addressed in this thesis. The qualitative responses were collated by the research assistants and reviewed by the candidate. No scientific analysis of the qualitative data was performed. Examples of responses are given in the result section to supplement the quantitative data.

Measures of Association

The relationship between the variables of RARA, practice size and global judgement of accreditation were explored. These have been compiled as cross-tabulations with numbers and percentages given. Where appropriate, extent of missing data is also indicated.

The *likelihood-ratio chi-square* (χ^2), commonly used in the analysis of categorical data, was used to measure association between variables.[85] The observed significance level (p) was also calculated. For the purposes of this report a significance level of less than 0.05 was used to assess the independence of variables. The null hypothesis was that the independent variables are related. Associations for which a p-value of less than 0.05 were observed resulted in a failure to reject the null hypothesis.

Multiple logistic regression was used to construct a predictive model to determine the relationship between RARA, practice size and overall compliance with the standards.

Reliability

Reliability of a measure can be defined as the degree of stability exhibited when a measurement is repeated under identical conditions. Reliability refers to the degree to which results obtained by a measurement procedure can be replicated. Lack of reliability may arise from divergences between observers or instruments of measurement or instability of the attribute being measured (REF Last).

Reliability of measurement using the Standards was evaluated by assessing agreement between the four practice compliance measures which occurred for each practice. These four measures all used the same assessment tool, the Entry Standards for General Practice (Appendix I). The Joint Assessment Form (Appendix XI) summarised the joint opinion of the two surveyors following resolution of any differences between their individual assessments using the Entry Standards document. As this summary is based on the use of the same instrument (the Entry Standards document) by the surveyors for individual assessment and by practices for self assessment and used identical categorical measurement, it could be compared with the self assessment carried out by the practices.

Inter rater reliability tests the consistency of scores obtained by different assessors when using the same measurement tool and examining the same set of criteria and standards. If the test is reliable the measurement tool behaves similarly in a variety of circumstances when administered by different assessors.

Two measures of inter-rater reliability were tested, level of agreement between the two surveyors judging the standards of the individual practice and level of agreement between the joint assessment of the surveyors and the self assessment of the practice.

Cohen's Kappa statistic (κ) is given for tables related to overall assessment. A Kappa statistic is a chance-corrected measure of agreement, comparing the observed level of agreement with the level of agreement expected by chance alone. A rating of agreement as described by Posner et al has been adopted for quantifying the strength of agreement.[86]

Internal consistency refers to the consistency of answers within a measurement instrument and is determined statistically by comparison of either two versions of the same instrument or parts of the one instrument tool where there are a number of items measuring the same concept. A split half reliability test is used where there is only one form of the instrument. In this method two scores are obtained for each assessment by dividing the test into equivalent halves and testing the agreement between the two sets of results. Internal consistency can also be assessed by measuring the consistency of responses to all items in the test using the 'Kuder-Richardson formula 20' or Cronbach's alpha.[87] Cronbach's alpha is appropriate where there are multiple possible responses to each test item and was therefore used in these tests.

A split-half reliability test was used to test the internal reliability of the standards. Criteria were divided alternatively into two parts to provide an even split (eg 1.1.1, 1.1.3, 1.1.5 in part A 1.1.2, 1.1.4, 1.1.6 etc in part B) then a score was calculated for a split-half coefficient.[88] This can be interpreted as a correlation coefficient, with a range in value of 0 to 1. Scores for Cronbach's alpha were also calculated for the separate parts of the split, providing a measure of internal reliability within each half.

Test-retest reliability is a measure of the extent to which a test provides a reliable measure on repeat occasions. A test-retest method was used by forcing both self and joint assessment into the one reliability model. This provided a measure of correlation between self assessment and joint assessment.

A further measure of reliability was used in the calculation of agreement between assessors for individual criteria. The simplest measure of agreement was obtained by calculating the proportion of times the assessors agreed based on 'substantial', 'partial' ,'nil' and 'N/A'. Data were also reduced to 2x2 tables, deriving the percent of practices who would have met the criterion, based on 'substantial', 'partial' and 'N/A' meeting of the criteria (see results on individual criteria).

The use of multiple regression analysis for predictive modelling of the items in the entry standards was carefully considered. In an instrument designed to test any set of attributes, predictive modelling can be used to select items that effectively discriminate between 'pass' and 'fail' and to eliminate items that fail to differentiate and may therefore be considered redundant. While logistic modelling could fulfil this role, discrimination or lack of it was not a criterion for the selection of individual items in the standards. This is because the standards had two distinct functions, firstly to define a set of attributes which were deemed desirable in all practices and secondly to be used as an instrument to measure the presence of those attributes. The primary aim was to include all attributes that were desirable in the knowledge that in some cases (almost) all practices would possess that attribute. Thus the criterion for determining inclusion was desirability not discrimination. In these circumstances predictive modelling served no useful purpose as the discriminating ability of the whole set of standards and the assessment method could be assessed by the reliability measures listed above.

Validity

Validity is defined as the degree to which a test or measurement measures what it purports to measure.[89] Measures of validity therefore seek to confirm that an instrument, tool or questionnaire actually measures what it is intended to measure. This is generally done by comparing the results of a new tool with that of an accepted or gold standard. There is no similar measurement of standards for general practice by which to compare the validity of the results of the Field Test. In this study the evaluation of validity emphasised face validity but content validity and criterion validity were also investigated.

CHAPTER 5

RESULTS

The Field Test of the RACGP Entry Standards for General Practice was undertaken to demonstrate the validity, acceptability and achievability of the standards and criteria, test the hypothesis that over 85% of practices would meet the standards, and demonstrate that the method of assessment was both reliable and feasible. This chapter describes the results of the Field Test in four sections. Section 5.1 describes the results of the recruitment of practices. Section 5.2 describes the results of the patient survey. Section 5.3 consolidates the overall test results under the conceptual headings of validity, acceptability, achievability, assessment of practices and reliability. Section 5.4 details the results for individual standards, criteria and indicators. The results are also condensed into tables with significant differences highlighted to assist interpretation. Notes and footnotes in section 5.4 of this chapter duplicate those in the Entry Standards and are not comments or references of this thesis.

5.1 Recruitment of practices

5.1.1 Recruitment of sample doctors

Beginning on 10 March 1994 initial letters were mailed out to sample doctors by state to coincide with surveyor training and thus avoid a long gap between surveyor training and practice visits.

A summary of letters sent and the recruitment results is provided in Table 5.1.

Table 5.1 Summary of recruitment by RARA (number of sample doctors)

	Total sample	RARA 1/2	RARA 3/5	RARA 4/6
Letters sent	400	228	90	82
Agreed to participate	199	99	50	50
Refused to participate	84	65	16	3
Doctors excluded	117	64	24	29

Recruitment ceased when 200 practices agreed to participate. However one practice withdrew late in the field test leaving 199 out of 283 eligible doctors in the field test - a response rate of 70.3%.

At telephone follow up 117 of the 400 sample doctors receiving a letter were excluded (Table 5.2), almost a third not being contactable.

Table 5.2 Reasons for excluding sample doctors

Reason for exclusion	Number	Percent
Not contactable	35	29.9
Prior involvement	19	16.2
Over quota	17	14.5
Retired	15	12.8
Not in general practice	13	11.1
Sample doctor away	11	9.4
Locum with no regular practice	6	5.1
Locum with practice in different RARA	1	0.9
TOTAL	117	100.0

5.1.2 Refusals

Eighty four sample doctors (29.7% of eligible sample doctors) refused to participate in the field test and 76 of these (90%) provided demographic data on their practice. These data were used to compare participating practices with refusing practices.

Over 70% of refusals were said to be due to time constraints or the inconvenience anticipated in the process of practice visits. However it is notable that 19 of the 84 practices had a philosophical objection to the concept of standards and accreditation.

An analysis of reasons for refusal appears below in Tables 5.3 to 5.5. There was no association between reason for refusal and RARA (χ^2=4.95, df=8, p=0.72) (Table 5.3), practice size (χ^2=9.52, df=8, p=0.30) (Table 5.4) or sex of sample doctor (χ^2=8.01, df=4, p=0.09) (Table 5.5).

Table 5.3 Reasons for refusal by RARA

Number Column %	**RARA 1/2**	**RARA 3/5**	**RARA 4/6**	**Total**
Time and inconvenience of visit	47 72.3	10 62.5	3 100.0	60 71.4
Philosophical opposition to standards and/or accreditation	14 21.5	5 31.3	0	19 22.6
Other	4 6.1	I 6.3	0	5 6.0
Total Row %	65 77.4	16 19.0	3 3.6	84 100.0

Table 5.4 Reasons for refusal by practice size

Number Column %	**Solo**	**1-2 doctors**	**4+ doctors**	**Total**
Time and inconvenience of visit	19 63.3	20 87.0	16 69.6	55 72.4
Philosophical opposition to standards and/or accreditation	9 30.0	2 8.7	5 21.7	16 21.1
Other	2 6.6	1 4.3	2 8.6	5 6.5
Total Row %	30 39.5	23 30.3	23 30.3	76 100.0

Table 5.5 Reasons for refusal by sex of sample doctor

Number Column %	**Female sample doctor**	**Male sample doctor**	**Total**
Time and inconvenience of visit	21 84.0	39 66.1	60 71.4
Philosophical opposition to standards and/or accreditation	3 12.0	16 27.1	19 22.6
Other	1 4.0	4 6.8	5 6.0
Total Row %	25 29.8	59 70.2	84 100.0

5.1.3 Participating practices

Of the 199 participating practices there were 50 (25.1%) solo practices, 65 (32.7%) medium sized practices (2-3 doctors) and 84 (42.2%) large practices (4+ doctors). While there was some variation in distribution of practice size in specific RARA, there was no significant association between rurality and size of practice (χ^2=7.36, df=4, p=0.12) (Table 5.6).

Table 5.6 Agreeing sample doctors by RARA and practice size

Number Row % Column %	**RARA 1/2**	**RARA 3/5**	**RARA 4/6**	**Total**
Solo	22 44.0 22.0	12 24.0 24.0	16 32.0 32.7	50 25.1
2-3 doctors	40 61.5 40.0	11 16.9 22.0	14 21.5 28.6	65 32.7
4+ doctors	38 45.2 38.0	27 32.1 54.0	19 22.6 38.8	84 42.2
Total Row %	100 50.3	50 25.1	49 24.6	199 100.0

5.1.4 Comparison of participating practices and refusals

GPs from rural and remote areas were more likely to agree to participate than those from major urban areas. Only 60% of sample practices from RARA 1/2 agreed to participate, compared to 76% from RARA 3/5 and 94% from RARA 4/6, (χ^2=27.79, df=2, p=<.001). Aggregation of results for GPs from rural and remote areas (RARA 3 to 6) demonstrated that 84% of GPs from RARA other than large urban areas agreed to participate, compared to 60% of GPs from large urban areas (χ^2=19.45, df=1, p=<0.001) (Table 5.7).

Table 5.7 Participation rates by RARA

Number Column %	**RARA 1/2**	**RARA 3/5**	**RARA 4/6**	***RARA 3-6***	**Total**
Agree	99 60.4	50 75.8	50 94.3	*100* *84.0*	199 70.3
Refuse	65 39.5	16 24.2	3 5.7	*19* *16.0*	84 29.7
Total Row %	164 58.1	66 23.3	53 18.7	*119* *42.0*	283 100.0

Solo practices were less likely to agree to participate than group practices (χ^2=5.31, df=1, p=0.02) (Table 5.8).

Table 5.8 Participation rates by practice size

Number Column %	**Solo**	**2-3 doctors**	**4+ doctors**	***2+ doctors***	**Total**
Agree	50 62.5	65 73.9	84 78.5	*149* *76.4*	199 72.4
Refuse	30 37.5	23 26.1	23 21.5	*46* *23.6*	76 27.6
Total Row %	80 29.1	88 32.0	107 38.9	*195* *70.9*	275 100.0

In comparative analyses in respect of gender, age, place of graduation and RACGP membership, data were available from agreeing contact GPs, refusing contact GPs and the rest of the GPs in the sample frame.

With regard to gender, there were no differences between sample doctors who agreed to participate, sample doctors who refused to participate and all other doctors in the sample frame (χ^2=1.92, df=2, p=0.38) (Table 5.9). Similarly there were no significant gender differences between sample doctors who agreed to participate and those who refused (χ^2=1.15, df=1, p=0.28).

Table 5.9 Gender of GPs who agreed and refused to participate and the remaining population

Number Row %	**Males**	**Females**	**Total**
Agree	152 76.4	47 23.6	199
Refuse	59 70.2	25 29.8	84
Remaining population	10,415 72.2	4,007 27.8	14,422
Total	10,626 72.3	4079 27.7	14,705 100.0

In terms of age, there were no differences between sample doctors who agreed to participate, sample doctors who refused, and the remaining population (χ^2=3.93, df=6, p=0.69), nor were there any differences between sample doctors who agreed to participate and those who refused when age unknown was excluded from the analysis (χ^2=0.92, df=2, p=0.63) (Table 5.10).

Table 5.10 Age groups of GPs who agreed and refused to participate and the remaining population

Number Row %	**<35 years**	**35-54 years**	**>54 years**	**Unknown age**	**Total**
Agree	15 7.5	127 63.8	40 20.1	17 8.5	199
Refuse	9 10.7	49 58.3	16 19.0	10 11.9	84
Remaining population	1,658 11.0	8,967 59.7	3,054 20.3	1,329 8.9	15,008
Total	1,682 11.0	9,143 59.8	3,110 20.3	1,356 8.9	15,291 100.0

In respect to place of graduation no significant differences were found between sample doctors who agreed to participate, sample doctors who refused and the remaining doctors (χ^2=5.71, df=4, p=0.22) (Table 5.11), nor were there any differences between sample doctors who agreed to participate and those who refused (χ^2=0.02, df=1, p=0.88). Doctors who agreed to participate were more likely than the remaining doctors to have graduated in Australia, however, this difference was only marginally significant (χ^2=4.08, df=1, p=0.04).

Table 5.11 Place of graduation of GPs who agreed or refused to participate and the remaining population

Number Row %	**Australia**	**Overseas**	**Total**
Agree	155 82.0	34 18.0	189
Refuse	65 81.3	15 18.8	80
Remaining population	10,956 76.0	3,460 24.0	14,416
Total	11,176 76.1	3,509 23.9	14,685 100.0

With regard to membership of the RACGP, there was no significant relationship between sample doctors who agreed to participate, doctors who refused and remaining doctors (χ^2=4.56, df=2, p=0.10). However, RACGP members were more likely to agree to participate than non-members although this result only just reached significance (χ^2=3.94,df=1,p=0.047). There was a higher proportion of non-RACGP members in the group of doctors who refused than there was in the remaining group of doctors (χ^2=4.40,df=1,p=0.04) (Table 5.12).

Table 5.12 RACGP membership status of GPs who agreed and refused to participate and the remaining population

Number Row %	**RACGP Member**	**Non-Member**	**Total**
Agree	71 35.7	128 64.3	199
Refuse	20 23.8	64 76.2	84
Remaining population	5,161 34.4	9,847 65.6	15,008
Total	5,252 34.3	10,039 65.7	15,291 100.0

5.2 Patient survey

In spite of the time allowed for the collection and analysis of the patient survey data (see section 4.4.5), many practices had not completed their survey forms by the day of the visit, while others had completed the forms but had not yet received a report from the RACGP Research and Health Promotion Unit. It is estimated (from observer and surveyor reports) that survey results were only available in 20-25% of practices on the day of the visit.

Difficulties were also experienced by surveyors in interpreting the results.

> *"Some of the questions did not seem relevant to standards." (Surveyor, WA)*

> *"The presentation of data was not easily interpreted - some was positive and some was negative." (Surveyor, Vic)*

> *"This survey has some problems. The questions are not very relevant." (Surveyor, Qld)*

> *"The survey needs much better correlation with any standards assessment or accreditation process. I also think it is a bit too long and complicated." (Surveyor, NSW)*

> *"Information about practices was often very sketchy and incomplete." (Surveyor, SA)*

Despite the difficulties experienced, it was clear that a patient survey should be part of practice assessment because it provides a further tool for the evaluation of general practices, because of its acceptability to practices and because surveyors expressed a desire to have these data:

> *"I never saw a patient survey. Practices which had agreed to participate had either not sent them in yet or if they had been sent in, had not had the results sent back. It was a pity as I believe consumer views would have been relevant." (Surveyor, WA)*

While Patient Participation Programme survey has been a successful and valuable QA option for many years, it was concluded that the survey, in its current form, was not well suited to the needs of external surveyors assessing practices against the Entry Standards. It must also be concluded that incorporation of the survey was not a logistical success within the time-frame of the Field Test.

Additional questions in the current survey or a specifically designed questionnaire that relates directly to the standards document would be required for future practice visits. The development of such a questionnaire would require considerable expertise and a thorough understanding of the standards.

5.3 Consolidated Results

5.3.1 Validity

The evaluation of validity seeks to confirm that an instrument, tool or questionnaire actually measures what it intends to measure. The validity of a measuring instrument is the extent to which differences in measurement scores reflect true differences in the characteristic which it seeks to measure rather than constant or random errors.

The purpose of testing the validity of the field test of Entry Standards is to determine whether the Entry Standards adequately measure and reflect 'good' general practice.

Validity must be inferred by looking for evidence that the standards and criteria:

(i) are generally agreed to reflect good general practice (face validity);

(ii) cover all aspects of good general practice (content validity); and

(iii) predict some other characteristic of practices, in this case a global judgement from surveyors on whether the practice deserves to be accredited regardless of the standards (criterion validity).

Face validity

Face validity of the standards assessment instrument was measured for individual criteria by asking both practices and surveyors to respond, for each criterion, to the statement "This criterion reflects good general practice". A summary of responses is shown in Table 5.19. Face validity data for individual criteria are presented in detail in section 5.4.

Both surveyors and practices agreed that most of the criteria reflect good general practice. In several instances 100% of surveyors and practices agreed that a criterion reflected good practice. These criteria usually related to ethical issues and patient rights, for example, confidentiality of medical records, providing respectful care to patients and the patient's right to refuse any treatment. There was also 100% agreement on the criterion "The practice has equipment appropriate to the procedures performed in the practice", although the lack of specificity and lack of indicators may have aided support for this criterion.

Agreement scores of over 90% for both surveyors and practices were achieved on 57 (88%) of the 65 criteria. Both practices and surveyors scored less than 90% on only 5 (8%) of the criteria.

The lowest levels of agreement (both surveyor and practice scores being less than 90%) that the criterion reflects goods general practice were for practice information sheets, health pamphlets and brochures, substantial unusual costs, awareness of interpreter services and appointments within two working days.

Rural practices in RARA 3/5 were less likely to regard as valid, the criteria relating to advice by telephone (χ^2=10.15,df=4,p=0.04), consistency within the practice (χ^2=11.84,df=4,p=0.02) and health summaries in the medical record (χ^2=8.87,df=1,p<0.01).

Smaller practices were less likely to regard as valid, the criteria relating to practice information sheets (χ^2=13,36,df=2,p<0.01), provision of practice equipment (χ^2=8.60,df=1,p<0.01) and appropriate physical access (χ^2=13.74,df=4,p<0.01).

Content validity: comprehensiveness of the standards

Practices and surveyors were asked if there were any important issues not covered in the standards and criteria. The results are shown in Table 5.13.

Table 5.13 Were there any important issues not covered in the standards and criteria? - (numbers and percentages)

	Practices	**Surveyors**
Yes	39 (22.9%)	22 (37.3%)
No	131 (77.1%)	37 (62.7%)
Missing data	29	17

There were 35 suggestions from practices and 19 suggestions from surveyors as to what may be missing from the standards. This relatively small number would appear to indicate that most areas of importance to general practitioners are covered in the document.

An analysis of the suggestions showed that the absence of standards relating to doctor's health was of most concern to practices:-

> *"The standards did not seem to address the more (doctor & staff) personal issues of job satisfaction, ability to obtain locum, holidays etc and their effect on the quality of general practice." (Large practice)*

> *"Are doctors aware of the need, and taking steps to ensure that they have adequate leisure time away from the workplace, so as to avoid stress related illness, and drug addiction?" (Medium practice, SA)*

There was some concern from rural practices that the standards do not adequately address the relationships between rural practices and their local hospital. This was also raised by a number of rural surveyors:-

> *"It became very obvious through the six visits that these standards were written for city practice, and really did not get down to the nitty gritty of rural practice which is being the interface and provider of first and second degree care, both out-patient and in-patient. I was not given a chance to see if I would let the doctor/practice look after my mother through an MI for pre-hospital/hospital/convalescence/rehabilitation. The standards seemed to underestimate the level of expertise necessary for rural practice." (Rural surveyor, SA)*

Practices and surveyors provided a very broad range of suggestions, the most common of which are shown in Table 5.14 (practices) and Table 5.15 (surveyors).

Other ideas not shown in the tables included standards for excluding 'para-medical fringe practitioners', standards in which medical outcomes are explicitly stated and standards for locum pay.

Table 5.14 Practices: important issues not covered in the standards and criteria - (numbers and percentages)

Area of omission	Number of practices	
Doctor's health (breaks, holidays, rights)	6	(17.1%)
Relationship between practice and country hospitals	4	(11.4%)
Ethics of repeat prescriptions	2	(5.7%)
Computerisation of practices	2	(5.7%)
Other areas of omission	21	(60.0%)

Table 5.15 Surveyors: important issues not covered in the standards and criteria - (numbers and percentages)

Area of omission	Number of surveyors	
Specific standards for rural practices	5	(26.3%)
Doctor's health (breaks, holidays, rights)	4	(21.1%)
Quality of medical practice itself	3	(15.8%)
Nursing home visits	2	(10.2%)
Other areas of omission	6	(31.5%)

Surveyors were asked if there were any standards, criteria or indicators that should be removed. The results are shown in Table 5.16.

Table 5.16 Surveyors: Are there any standards, criteria or indicators you would remove? - (numbers and percentages)

Remove any standards, criteria or indicators?	Number of surveyors	
Yes	36	(61.0%)

No	23	(39.0%)
Missing data	17	

There were almost as many suggestions as there were responses and many of these were quite detailed. The most common suggestions are shown in Table 5.17.

Table 5.17 Surveyors: standards, criteria or indicators that should be removed - (numbers and percentages)

Area to be omitted	**Number of surveyors**	
1.2.1 Practice information sheet	5	(13.9%)
*1.1.1 Appointment in two working days	4	(11.1%)
*1.2.4 Costs of treatment	4	(11.1%)
Other suggested areas	23	(63.9%)

Criterion validity: joint assessed accreditation and global judgement

Validity may also be measured by the relationship between whether or not practices would have been accredited and the 'global judgement' made by surveyors. In other words, a valid set of standards would not accredit a 'bad' practice, nor would they 'fail' a 'good' practice.

There was a significant positive correlation between the surveyor's global judgement and practice accreditation (Pearson correlation coefficient; $r=0.3413$, $p<0.01$). No practices considered 'bad' by global judgement would have been accredited, although 38.9% of 'good' practices would not have been accredited (Table 5.18). This may indicate that the standards are set 'too high', although the achievability of standards and criteria not met by many of these 'good' practices should be taken into account when considering this outcome.

Table 5.18 Global Judgement by Accreditation

		Surveyor's Global Judgement		
	n Col %	Would accredit	Would not accredit	Total
Joint Assessed Accreditation	Yes	107 61.1	0	107 56.0
	No	68 38.9	16 100.0	84 44.0
	Total	175 91.6	16 8.4	Agreement 64.4%

Table 5.19 Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.1 Access and availability								
*1.1.1 within two working days	85	88	90	84	88	93	93	82
*1.1.2 advice by telephone	92	92	**94**	**89**	**93**	92	89	95
*1.1.3 off site visits	98	99	100	98	98	98	100	99
*1.1.4 urgent matters	100	99	99	100	100	98	100	100
*1.1.5 24 hour cover	97	98	98	96	100	93	98	100
*1.1.6 flexible appointments system	97	99	100	96	100	95	100	100
1.2 The consultation and communication								
1.2.1 practice information sheet	80	74	80	64	71	**59**	**66**	**88**
*1.2.2 consultation length	90	89	92	85	88	86	85	93
*1.2.3 risks of treatments	95	96	95	96	98	88	96	100
*1.2.4 substantial/unusual costs	82	88	89	82	93	81	91	90
*1.2.5 patients with different language	85	85	92	76	80	85	81	87
*1.2.6 health pamphlets and brochures	78	87	90	82	86	84	85	90
1.3 Diagnosis/manage. of health problems								
*1.3.1 consistency with wider profession	100	99	99	100	100	100	100	99
1.3.2 consistency within the practice	87	92	**93**	**82**	**100**	88	94	92
1.4 Content of medical records								
*1.4.1 sufficient information	100	99	100	98	98	98	100	99
1.4.2 current health summary	98	93	**96**	**84**	**98**	93	93	94
*1.4.3 storage of non-active records	95	95	94	93	98	88	96	97
1.5 Continuity of care								
*1.5.1 relevant standards	100	99	99	100	100	100	98	100
*1.5.2 doctor of choice	97	99	100	98	100	100	98	100
1.6 Integration of care								
*1.6.1 knowledge/interaction	100	98	98	96	100	95	98	99
*1.6.2 referral letters	97	99	98	100	100	100	96	100
1.7 Health promotion...								
*1.7.1 opportunistic preventive care	98	98	99	98	98	95	98	100
1.7.2 systematic preventive care	90	86	90	79	86	83	83	90
*1.7.3 education and information	93	97	98	93	98	98	94	97
1.7.4 local health programs	90	92	93	87	95	85	96	92
2.1 Rights and needs of patients								
*2.1.1 respectful care	100	100	100	100	100	100	100	100
*2.1.2 right to privacy	100	100	100	100	100	100	100	100
*2.1.3 record confidentiality	100	99	100	98	100	100	100	99
*2.1.4 right to refuse treatment	100	100	100	100	100	100	100	100
*2.1.5 right to further opinion	98	99	99	98	100	100	96	100
*2.1.6 right to transfer from practice	100	99	100	98	100	98	100	100
*2.1.7 consent: clinical training	100	93	94	89	95	88	91	97
*2.1.8 consent: research programs	97	93	94	95	89	90	94	93
*2.1.9 acknowledges complaints	100	99	100	98	100	100	98	100
*2.1.10 privacy of accounts	98	99	99	98	100	98	98	100
3.1 Quality assurance & continuing education								
*3.1.1 medical staff	100	95	95	94	95	91	96	96
3.1.2 staff involved in patient care	100	96	95	96	100	93	98	97
*3.1.3 administrative review	98	94	95	91	93	86	93	99
4.1 Practice staff								
*4.1.1 person for practical help	97	98	99	94	100	93	100	99
*4.1.2 inter-personal skills	100	98	99	98	98	95	98	100
4.2 Medical records system								
*4.2.1 comprehensive, well organised	97	100	100	100	100	100	100	100
*4.2.2 confidentiality	100	100	100	100	100	100	100	100
*4.2.3 transfer on request	98	98	100	96	98	98	98	99
*4.2.4 follow up abnormal results	100	99	99	100	100	98	100	100
4.3 Control of practice								
*4.3.1 clinical autonomy	100	98	98	98	100	100	98	97
5.1 Practice facilities								
*5.1.1 one consultation room per doctor	100	99	100	98	100	100	98	100
*5.1.2 facilities in consultation room	100	99	99	98	100	100	96	100
5.1.3 waiting area	98	98	99	96	100	98	96	100
*5.1.4 toilets/hand washing facilities	98	99	100	98	100	98	100	100
*5.1.5 privacy for distressed	100	98	98	96	100	93	98	100
5.1.6 telecommunications system	100	99	100	98	98	95	100	100
5.1.7 medical & other records storage	100	98	99	96	98	98	98	97
5.1.8 practice security	100	99	99	100	98	98	98	100
*5.1.9 sterilisation, disinfection...	98	99	100	98	100	98	100	100
*5.1.10 contaminated waste disposal	98	97	99	91	100	93	98	99
*5.1.11 sharps disposal	100	99	100	98	100	100	98	100
5.1.12 safety of doctors & staff	97	97	96	96	100	95	94	100
*5.1.13 well maintained, visibly clean	100	99	100	98	100	98	100	100
5.2 Practice equipment								
*5.2.1 medical equipment	98	98	99	98	98	**93**	**100**	**100**
*5.2.2 doctors bag	98	98	99	98	98	95	98	100
*5.2.3 vaccine storage	95	99	100	98	100	100	100	99
*5.2.4 equipment for procedures	100	100	100	100	100	100	100	100
5.2.5 resources and reference materials	98	98	100	100	93	93	100	100
5.3 Physical access								
5.3.1 appropriate physical access	97	97	99	93	97	**91**	**98**	**100**
*5.3.2 off site visits (limited access)	98	98	100	96	100	98	98	100

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, = statistically significant..

5.3.2 Acceptability

The evaluation of standards in general practices can only be successful on a national basis if the profession as a whole regards the standards and the assessment method as acceptable.

Acceptability of the standards was measured for individual criteria by asking both practices and surveyors to respond, for each criterion, to the statement "This criterion is acceptable in a set of minimum standards". A summary of responses is shown in Table 5.20.

Acceptability scores were generally very high with 58 (89%) out of 65 criteria rated as acceptable by more than 80% of practices and surveyors. Highest levels of acceptability (no score below 90%) were achieved for the criteria under Standard 4.2 (medical records system), Standard 4.3 (control of practice) and Standard 5.1 (practice facilities).

The criteria with the highest levels of acceptability related to ethical and patients rights issues such as the right to privacy and confidentiality of medical records and other documents. Criteria relating to sharps disposal and equipment for procedures also rated very highly.

Lowest levels of acceptability (both surveyors and practices score less than 80%) were for practice information sheets, discussion of substantial or unusual costs with patients, the provision of health pamphlets and brochures, provision of systematic preventive care, and knowledge of local health programs.

The lowest score was obtained for the practice information sheet with only 54% of practices agreeing that this criterion was acceptable in a set of minimum standards. Seventy one percent of surveyors agreed the criterion was acceptable.

All rural practices were less likely to regard as acceptable criteria relating to availability of a doctor within two days (χ^2=9.12,df=2,p=0.01) and provision of health information (χ^2=6.86,df=1,p<0.01). RARA 4/6 practices were less likely to regard as acceptable criteria relating to sterilisation requirements (χ^2=5.70,df=1,p=0.02). Small practices were less likely to regard as acceptable criteria relating to practice information sheets (χ^2=10.4,df=2,p<0.01), provision of care to all patients presenting (χ^2=8.84,df=1,p<0.01), rights to transfer from the practice (χ^2=4.96,df=1,p=0.03), sterilisation facilities (χ^2=5.80,df=1,p=0.02) and provision of appropriate physical access (χ^2=5.14,df=1,p=0.02). Large practices (> 4 doctors) were less likely to regard as acceptable criteria relating to the provision of one consultation room per doctor (χ^2=10.76.df=4,p=0.03).

While these differences were statistically significant, they were frequently of very small magnitude and therefore not of practical importance. The possibility of type 2 statistical errors must also be kept in mind.

The following quotations are typical of comments relating to acceptability of the standards and the pilot accreditation process:

> *"I think having standards is a useful thing. Taxpayers fund the medical profession and should have concrete insurance that appropriate standards are being met." (Large practice, Qld)*

> *"I am unhappy with the concept of income being in any way dependent on accreditation or standards." (Solo practice, Qld)*

> *"The survey is something long overdue in general practice and having experienced some other GP practices in this area - I would be quite frankly 'ashamed' to work in such places." (Solo practice, Vic)*

Table 5.20 Response to : "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.1 Access and availability								
*1.1.1 within two working days	83	81	**90**	**74**	**71**	88	85	75
*1.1.2 advice by telephone	85	84	87	77	85	73	87	87
*1.1.3 off site visits	95	96	96	95	98	93	96	99
*1.1.4 urgent matters	98	99	98	100	100	98	99	100
*1.1.5 24 hour cover	95	92	92	95	90	85	91	97
*1.1.6 flexible appointments system	90	90	93	84	90	85	87	94
1.2 The consultation and communication								
1.2.1 practice information sheet	71	54	59	48	50	**43**	**43**	**68**
*1.2.2 consultation length	86	81	83	80	78	80	82	81
*1.2.3 risks of treatments	83	91	94	84	93	85	91	94
*1.2.4 substantial/unusual costs	64	77	79	67	82	72	74	82
*1.2.5 patients with different language	83	70	76	59	67	74	62	72
*1.2.6 health pamphlets and brochures	71	77	**84**	**68**	**73**	75	72	82
1.3 Diagnosis/manage. of health problems								
*1.3.1 consistency with wider profession	93	98	96	100	98	98	96	99
1.3.2 consistency within the practice	83	82	82	71	93	82	82	82
1.4 Content of medical records								
*1.4.1 sufficient information	95	97	99	93	98	98	94	99
1.4.2 current health summary	78	80	83	72	83	70	81	86
*1.4.3 storage of non-active records	97	86	87	74	98	76	87	90
1.5 Continuity of care								
*1.5.1 relevant standards	100	98	96	98	100	98	98	97
*1.5.2 doctor of choice	93	89	92	84	90	88	91	89
1.6 Integration of care								
*1.6.1 knowledge/interaction	88	90	91	89	88	83	93	92
*1.6.2 referral letters	95	96	94	96	100	95	93	99
1.7 Health promotion...								
*1.7.1 opportunistic preventive care	88	91	90	93	88	93	87	92
1.7.2 systematic preventive care	67	73	78	69	65	72	74	72
*1.7.3 education and information	85	89	90	86	90	93	85	90
1.7.4 local health programs	68	73	74	68	74	62	81	72
2.1 Rights and needs of patients								
*2.1.1 respectful care	97	98	99	98	95	**90**	**100**	**100**
*2.1.2 right to privacy	100	99	100	98	100	98	100	100
*2.1.3 record confidentiality	100	99	100	96	100	98	100	99
*2.1.4 right to refuse treatment	95	98	99	98	95	92	100	99
*2.1.5 right to further opinion	95	95	95	91	98	93	94	96
*2.1.6 right to transfer from practice	97	96	96	96	98	**88**	**100**	**99**
*2.1.7 consent: clinical training	91	90	91	86	93	84	92	92
*2.1.8 consent: research programs	90	87	90	84	85	82	92	86
*2.1.9 acknowledges complaints	91	90	92	88	90	85	91	93
*2.1.10 privacy of accounts	95	97	98	95	97	95	98	97
3.1 Quality assurance & continuing education								
*3.1.1 medical staff	90	90	87	96	90	82	94	92
3.1.2 staff involved in patient care	86	93	91	93	95	87	96	93
*3.1.3 administrative review	83	81	83	77	83	73	83	85
4.1 Practice staff								
*4.1.1 person for practical help	93	87	88	86	88	88	93	83
*4.1.2 inter-personal skills	91	92	94	91	90	90	93	93
4.2 Medical records system								
*4.2.1 comprehensive, well organised	91	95	99	89	95	95	98	93
*4.2.2 confidentiality	100	99	99	98	100	98	98	100
*4.2.3 transfer on request	97	95	94	93	100	90	94	99
*4.2.4 follow up abnormal results	95	98	98	100	98	98	98	99
4.3 Control of practice								
*4.3.1 clinical autonomy	100	98	98	95	100	97	98	97
5.1 Practice facilities								
*5.1.1 one consultation room per doctor	98	93	95	91	93	**100**	**96**	**88**
*5.1.2 facilities in consultation room	98	97	96	96	100	100	96	96
5.1.3 waiting area	91	93	94	96	90	95	91	94
*5.1.4 toilets/hand washing facilities	98	98	99	98	98	95	100	99
*5.1.5 privacy for distressed	95	92	93	91	90	90	96	89
5.1.6 telecommunications system	95	93	96	91	90	95	91	94
5.1.7 medical & other records storage	97	94	95	91	95	95	94	93
5.1.8 practice security	98	94	94	96	93	93	94	94
*5.1.9 sterilisation, disinfection...	98	97	**96**	**100**	**95**	**90**	**98**	**100**
*5.1.10 contaminated waste disposal	95	96	96	91	100	93	96	97
*5.1.11 sharps disposal	100	99	100	96	100	98	98	100
5.1.12 safety of doctors & staff	91	90	93	82	95	88	87	94
*5.1.13 well maintained, visibly clean	98	95	95	93	97	93	92	99
5.2 Practice equipment								
*5.2.1 medical equipment	93	94	95	91	93	90	98	92
*5.2.2 doctors bag	97	97	98	96	98	95	96	99
*5.2.3 vaccine storage	93	96	98	93	95	92	98	96
*5.2.4 equipment for procedures	100	99	99	98	100	95	100	100
5.2.5 resources and reference materials	88	90	93	91	83	83	91	93
5.3 Physical access								
5.3.1 appropriate physical access	84	86	84	84	93	**76**	**83**	**94**
*5.3.2 off site visits (limited access)	98	94	94	93	97	92	93	97

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, = statistically significant.

5.3.3 Achievability

A set of minimum or entry standards must be achievable (and be perceived to be achievable) by general practitioners. Minimum standards and criteria that cannot be achieved would result in failure of any national assessment program.

Achievability of the standards assessment instrument was measured for individual criteria by asking practices to respond, for each criterion, to the statement "This criterion is achievable in this practice presently or with minimal change". Surveyors were asked a slightly different question to take advantage of their broader experience. They were asked to respond, for each criterion, to the statement "This criterion is achievable in practices presently or with minimal change." A summary of responses to both statements is shown in Table 5.21.

Achievability data are presented in more detail in the section dealing with individual criteria.

Achievability scores were generally very high with 50 (77%) out of 65 criteria rated as achievable by greater than 80% of practices and surveyors.

In almost every case (60 out of 65) the practice score was higher than the surveyor score (although for individual criteria this would rarely have been significant).

Nevertheless surveyors tended to regard the criteria as less achievable than practices. This appeared to be particularly the case (significance was not tested) for consultation length, discussion of costs, the criteria under Standard 1.7 (health promotion), staff training, administrative review, sterilisation, contaminated waste disposal, safety of doctors and staff and physical access. This result may of course reflect the different questions asked of practices and surveyors.

The criteria with the highest levels of achievability related to ethical and patient rights issues such as the right to privacy, confidentiality of medical records, and the right of patients to leave practices. The most achievable criterion was 1.1.4 - "A doctor is available to see patients for urgent medical matters."

Lowest levels of achievability were for health summaries and practice information sheets. The lowest score was obtained for non essential criterion 1.4.2 (the patient's individual medical record includes a current health summary) with only 46% of surveyors agreeing that this criterion was achievable by practices. However 79% of practices believed that this criterion was achievable in their practice.

Rural practices were less likely to regard as achievable criteria relating to availability of a doctor within two working days (χ^2=12.87,df=4,p=0.01), availability of a doctor of choice (χ^2=8.84,df=1,p<0.01), the provision of systematic preventive care (χ^2=10.39,df=2,p<0.01) and provision of a 'doctor's bag' (χ^2=4.53,df=1,p=0.03).

Small practices were less likely to regard as achievable criteria relating to availability of a doctor of choice (χ^2=4.52,df=1,p=0.03).

Large practices were less likely to regard as achievable criteria relating to availability of a doctor within two working days (χ^2=12.85,df=4,p=0.01).

Some of these statistical differences were of very small magnitude and therefore of little practical importance.

The following quotation is typical of the comments from practices.

> *"We felt that we were able to meet most of the criteria, and that those not met should be readily achievable. Some of the standards would be easier to achieve in a group practice such as this." (Large practice, NSW)*

Table 5.21 Response to : "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.1 Access and availability								
*1.1.1 within two working days	83	92	**99**	**87**	**85**	**100**	**96**	**85**
*1.1.2 advice by telephone	92	97	98	93	100	98	94	99
*1.1.3 off site visits	93	99	100	98	98	98	100	99
*1.1.4 urgent matters	100	100	100	100	100	100	100	100
*1.1.5 24 hour cover	86	97	95	100	98	95	96	99
*1.1.6 flexible appointments system	88	98	100	98	95	98	98	99
1.2 The consultation and communication								
1.2.1 practice information sheet	83	81	84	76	80	69	79	88
*1.2.2 consultation length	78	95	95	93	98	95	93	97
*1.2.3 risks of treatments	81	96	96	98	95	92	100	96
*1.2.4 substantial/unusual costs	67	90	91	92	85	88	93	89
*1.2.5 patients with different language	79	72	79	68	62	74	60	80
*1.2.6 health pamphlets and brochures	90	94	94	91	95	93	93	95
1.3 Diagnosis/manage. of health problems								
*1.3.1 consistency with wider profession	90	99	99	98	100	100	100	97
1.3.2 consistency within the practice	81	94	95	85	100	97	94	92
1.4 Content of medical records								
*1.4.1 sufficient information	63	95	94	91	90	95	91	92
1.4.2 current health summary	46	79	81	74	81	87	68	83
*1.4.3 storage of non-active records	91	97	96	96	100	98	98	96
1.5 Continuity of care								
*1.5.1 relevant standards	90	100	100	100	100	100	100	100
*1.5.2 doctor of choice	90	95	**99**	**95**	**87**	**82**	**100**	**94**
1.6 Integration of care								
*1.6.1 knowledge/interaction	85	99	98	100	100	98	100	99
*1.6.2 referral letters	83	99	99	98	100	97	100	99
1.7 Health promotion...								
*1.7.1 opportunistic preventive care	78	96	99	94	93	98	94	96
1.7.2 systematic preventive care	58	81	**90**	**75**	**71**	83	83	80
*1.7.3 education and information	80	93	94	93	90	95	93	92
1.7.4 local health programs	63	92	92	89	95	80	98	93
2.1 Rights and needs of patients								
*2.1.1 respectful care	97	99	99	100	100	98	100	100
*2.1.2 right to privacy	98	99	99	100	100	98	100	100
*2.1.3 record confidentiality	98	100	100	100	100	100	100	100
*2.1.4 right to refuse treatment	97	99	99	100	100	97	100	100
*2.1.5 right to further opinion	91	99	100	98	100	100	98	100
*2.1.6 right to transfer from practice	100	99	99	100	100	100	98	100
*2.1.7 consent: clinical training	93	89	92	86	88	81	92	92
*2.1.8 consent: research programs	91	84	90	81	75	87	88	78
*2.1.9 acknowledges complaints	86	98	99	98	98	98	96	100
*2.1.10 privacy of accounts	93	99	98	100	100	98	98	100
3.1 Quality assurance & continuing education								
*3.1.1 medical staff	81	95	95	93	98	90	98	96
3.1.2 staff involved in patient care	72	91	88	95	93	85	90	96
*3.1.3 administrative review	70	91	90	89	93	83	89	96
4.1 Practice staff								
*4.1.1 person for practical help	90	97	95	98	98	90	98	99
*4.1.2 inter-personal skills	90	97	96	98	98	93	100	97
4.2 Medical records system								
*4.2.1 comprehensive, well organised	62	88	89	83	90	93	89	84
*4.2.2 confidentiality	95	99	100	100	98	98	100	100
*4.2.3 transfer on request	95	98	99	98	98	98	98	99
*4.2.4 follow up abnormal results	81	96	94	100	95	95	94	97
4.3 Control of practice								
*4.3.1 clinical autonomy	93	99	97	100	100	100	98	99
5.1 Practice facilities								
*5.1.1 one consultation room per doctor	95	98	98	98	100	97	96	100
*5.1.2 facilities in consultation room	97	98	98	98	100	100	94	100
5.1.3 waiting area	85	98	100	96	98	98	98	99
*5.1.4 toilets/hand washing facilities	90	99	99	100	100	98	100	100
*5.1.5 privacy for distressed	90	96	94	100	95	**88**	**96**	**100**
5.1.6 telecommunications system	91	98	99	98	98	95	98	100
5.1.7 medical & other records storage	88	96	95	98	95	93	96	97
5.1.8 practice security	95	96	95	100	93	95	96	96
*5.1.9 sterilisation, disinfection...	76	92	90	96	95	88	92	96
*5.1.10 contaminated waste disposal	76	94	94	93	95	93	93	96
*5.1.11 sharps disposal	95	98	100	96	95	98	96	99
5.1.12 safety of doctors & staff	79	95	94	96	98	93	93	99
*5.1.13 well maintained, visibly clean	96	99	98	100	100	95	100	100
5.2 Practice equipment								
*5.2.1 medical equipment	83	96	95	98	95	90	98	97
*5.2.2 doctors bag	91	96	**98**	**98**	**93**	95	96	97
*5.2.3 vaccine storage	85	97	98	98	95	100	96	96
*5.2.4 equipment for procedures	98	100	100	100	100	100	100	100
5.2.5 resources and reference materials	85	98	98	100	95	95	98	99
5.3 Physical access								
5.3.1 appropriate physical access	70	91	90	96	85	88	89	93
*5.3.2 off site visits (limited access)	95	99	99	98	100	97	98	100

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, = statistically significant.

5.3.4 Assessment of practices

"I do not fear the accreditation process as we have experienced it. In fact I would now encourage it." (Surveyor, Vic)

For purposes of the field test, the Standards Working Party adopted a model in which practices must meet every entry standard in order to be accredited. The standards document distinguishes between essential criteria for each standard (which must be met in order to meet the standard) and desirable criteria (which do not have to be met). The standards document contained 52 criteria marked as essential.

Criteria were deemed to be met where a rating of either substantial or partial had been given by the surveyors (joint assessment) or the practices (self assessment).

One of the key objectives of the field test was to assess the percentage of practices likely to be accredited using this model. When practices were recruited however it was explained to them that they were not expected to try to 'come up to standard' before the visit as it was important for other objectives of the field test (validity, reliability etc) to assess practices 'warts and all'. It would be fair to assume that practices applying for accreditation would prepare their practices more thoroughly and therefore perform better than practices in the field test.

Table 5.22 shows that 55.3% (by joint assessment) of practices participating in the field test would have been accredited if this model was used for accreditation (this percentage was 69.0% for self assessment (Table 5.23)). It must be stressed that of the practices that would not have been accredited over 75% failed only one or two criteria. By joint assessment, these were most likely to be 5.2.3 (vaccine storage) and 5.1.10 (contaminated waste disposal) which over 97% of practices agreed reflected good general practice, 96% agreed were acceptable in a set of minimum standards and over 94% believed were achievable with minimal change.

It should be noted that in several instances surveyors or practices had inadvertently skipped a criterion while filling in their assessment and therefore data may only have been available on, for example, 51 out of the 52 essential criteria. Of the 197 complete Joint Assessments, 9 were missing 1 essential criterion and 2 were missing 2 essential criteria. Of the 197 Self Assessments, 19 were missing 1 essential criterion, 10 were missing 2, 6 were missing 3 and 3 were missing 4 essential criteria. All these practices were included in the analysis with missing data being counted as a 'pass' on the missing criterion.

Standards

Of the practices that would not have been accredited the majority (53% for joint assessment and 74% for self assessment) failed only one standard. Of the remainder the majority failed only two standards (31% for joint assessment and 15% for self assessment) therefore 84% failed in 1 or 2 standards by joint assessment and 89% by self assessment.

An analysis of standards not met in practices which only failed one criterion revealed that Standard 5.2 (practice equipment) and 5.1 (practice facilities) were the most common standards not met.

Accreditation by RARA and practice size

The tables below suggest that, for joint assessment, solo practices are less likely to meet the standards, while practices in RARA 4/6 are more likely to meet them. In neither case however was this statistically significant. It must be concluded that neither practice size nor RARA grouping influenced accreditation.

The regression model indicates that neither RARA classification nor practice size were predictive of joint assessed accreditation (χ^2=4.11,df=4,p=0.39).

Table 5.22 Joint assessment by RARA and practice size (number and % met)

Result		All	R1	R3	R4	So	2+	4+
Accredited	N	109	54	26	29	23	35	51
	%	55.3	54.5	52.0	60.4	46.0	54.7	61.4
Not accredited	N	88	45	24	19	27	29	32
	%	44.7	45.5	48.0	39.6	54.0	45.3	38.6

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons,

Table 5.23 Self assessment by RARA and practice size (number and % met)

Result		All	R1	R3	R4	So	2+	4+
Accredited	N	136	73	35	28	32	45	59
	%	69.0	74.5	70.0	57.1	64.0	70.3	71.1
Not accredited	N	61	25	15	21	18	19	24
	%	31.0	25.5	30.0	42.9	36.0	29.7	28.9

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons,

There was no significant difference between self assessment and joint assessment across RARA (χ^2=1.22,df=2,P=0.54) or practice size. It is also interesting to note that practices in RARA 4/6 appear equally likely to be accredited by self or joint assessment but practices in RARA 1/2 and 3/5 appeared more likely to be accredited by self assessment. Again, this was not significant (χ^2=1.22,df=1,P=0.26). (Table 5.23)

Global Judgement

In addition to rating practices on each criterion (which determines whether a practice is accredited or not), surveyors were asked to arrive at a joint global judgement of the practice.

This judgement was provided in response to the question “If this assessment had been a formal accreditation visit, do you think this practice should have been accredited or should not have been accredited?”. It was stressed to surveyors in training that their answer to this question should be based on a subjective assessment as to whether it would be fair to ‘accredit’ the practice regardless of its performance on the *Entry Standards*, ie regardless of whether all essential criteria were met.

This was done in order to provide an overall impression of the practice (made by experienced general practitioners) which could then be compared to practice performance on the standards and criteria.

Table 5.24 shows that the surveyors regarded 88.8% of practices as being worthy of accreditation.

Global Judgement by RARA and practice size

As with accreditation, there was no statistically significant relationship between either RARA and global judgement or practice size and global judgement (Table 5.24).

Table 5.24 Global judgement by RARA and practice size (number and % met)

Result		All	R1	R3	R4	So	2+	4+
Surveyors would accredit	N	175	85	47	43	42	58	75
	%	88.8	85.9	94.0	89.6	84.0	90.6	90.4
Surveyors would not accredit	N	16	11	2	3	7	4	5
	%	8.1	11.1	4.0	6.3	14.0	6.3	6.0
Surveyors did not know	N	6	3	1	2	1	2	3
	%	3.0	3.0	2.0	4.2	2.0	3.1	3.6

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons,

Relationship between Accreditation and Global Judgement

There was a significant positive correlation between the surveyor's global judgement and joint assessed practice accreditation (r=0.3413, p<0.01). No practices considered 'bad' by global judgement would have been accredited, although 38.9% of 'good' practices by global assessment would not have been accredited by joint assessment (Table 5.25).

Table 5.25 Global Judgement by Joint Assessed Accreditation

		Surveyor's Global Judgement		
	n Col % %	Would accredit	Would not accredit	Total
Joint Assessed Accreditation	Yes	107 61.1	0	107 56.0
	No	68 38.9	16 100.0	84 44.0
	Total	175 91.6	16 8.4	Agreement 64.4%

Performance against criteria

Joint assessment.

Of the practices that would not have been accredited, the majority (75% for joint assessment and 88% for self assessment) failed only one or two criteria.

An analysis of criteria not met in practices which only failed one criterion revealed that criteria 5.2.3 (vaccine storage) (41%) and 5.1.10 (contaminated waste disposal) (23%) were the most common essential criteria not met when practices failed to meet only one (Table 5.26).

Other criteria which were passed by less than 90% of practices included practice information sheets (49%), current health summaries (61%), systematic preventive care (79%) involvement in local health programs (88%) and training of staff (88%). These were all non-essential criteria.

Metropolitan practices were more likely to fail criteria regarding local health programs (χ^2=20.89,df=1,p<0.01) and toilets/hand washing facilities (χ^2=11.49,df=4,p=0.02). Practices from RARA 1/2 and 3/5 were more likely to fail criteria on sterilisation than practices from RARA 4/6 (χ^2=10.36,df=1,p<0.01). Smaller practices were more likely to fail criteria regarding practice information sheets (χ^2=28.72,df=2,p<0.01), confidentiality of records (χ^2=5.14,df=1,p=0.04), privacy for patients in distress (χ^2=5.56,df=1,p=0.02), practice security (χ^2=7.75,df=1,p<0.01), sterilisation (χ^2=8.19,df=1,p<0.01) and safety of staff (χ^2=4.39,df=1,p=0.04). Smaller practices were less likely to be assessed as complying 'substantially' with the criteria regarding medical equipment (χ^2=9.65,df=4,p=0.05).

Self assessment.

Criteria which were passed by less than 90% of practices by self assessment included those regarding practice information sheets (70%), patients speaking other languages (89%), health summaries (84%), systematic preventive care (84%), involvement in local health programs (85%) and staff training (88%).

Practices from RARA 3/5 were more likely to fail criteria regarding practice information sheets (χ^2=13.89,df=6,p=0.03). Practices from RARA 1/2 were more likely to fail criteria relating to involvement in local health programs (χ^2=6.00,df=1,p=0.01) (Table 5.27).

Performance of practices against the 65 criteria for joint and self assessment is summarised in Tables 5.26 and 5.27.

Comments on accreditation

The following is a brief selection of practice comments on accreditation:

> *"A difficult task for you. I am unsure if practice accreditation will genuinely ensure higher standards, in the same way that vocational registration does not ensure a better practitioner, but it is a good place to start. Good luck!" (Small practice, Qld)*
>
> *"One finds, again, that voluntary criteria for acceptable standards etc. will eventually be absolute criteria and associated power plays in the medical profession. Thus, this exercise is viewed with considerable distrust by most of us in the country. We have been through several of these sorts of episodes/reviews/standards/guidelines in the past, and they all have ended the same way." (Small practice, SA)*
>
> *"You should not expect all doctors and practices to conform and be identical - there must be some scope for individuals. Doctors are professionals which implies striving for excellence. Having guidelines to measure yourself against is helpful however, to be inspected is an intrusion." (Solo practice, QLD)*

Table 5.26 ***Joint assessment by RARA and practice size (% met)***

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.1 Access and availability	**98**	**97**	**98**	**98**	**94**	**98**	**99**
*1.1.1 within two working days	100	99	100	100	100	100	99
*1.1.2 advice by telephone	100	100	100	100	100	100	100
*1.1.3 off site visits	99	98	100	100	98	100	99
*1.1.4 urgent matters	99	98	100	98	96	98	100
*1.1.5 24 hour cover	100	100	98	100	98	100	100
*1.1.6 flexible appointments system	100	100	100	100	100	100	100
1.2 The consultation and communication	**96**	**98**	**92**	**96**	**94**	**95**	**98**
1.2.1 practice information sheet	49	50	50	48	**32**	**36**	**70**
*1.2.2 consultation length	100	100	98	100	100	98	100
*1.2.3 risks of treatments	100	100	98	100	100	100	99
*1.2.4 substantial/unusual costs	99	99	98	98	98	98	99
*1.2.5 patients with different language	100	100	100	100	100	100	100
*1.2.6 health pamphlets and brochures	98	99	96	98	96	98	99
1.3 Diagnosis/manage. of health problems	**98**	**97**	**100**	**98**	**96**	**98**	**99**
*1.3.1 consistency with wider profession	98	97	100	98	96	98	99
1.3.2 consistency within the practice	96	96	94	98	98	92	98
1.4 Content of medical records	**93**	**93**	**92**	**94**	**86**	**95**	**95**
*1.4.1 sufficient information	93	94	92	93	86	97	95
1.4.2 current health summary	61	60	60	65	64	63	58
*1.4.3 storage of non-active records	99	98	100	98	96	98	100
1.5 Continuity of care	**100**	**100**	**98**	**100**	**100**	**98**	**100**
*1.5.1 relevant standards	100	100	98	100	100	98	100
*1.5.2 doctor of choice	100	100	100	100	100	100	100
1.6 Integration of care	**98**	**99**	**94**	**98**	**96**	**97**	**99**
*1.6.1 knowledge/interaction	100	100	100	100	100	100	100
*1.6.2 referral letters	97	99	94	98	96	97	99
1.7 Health promotion...	**98**	**99**	**92**	**100**	**98**	**98**	**96**
*1.7.1 opportunistic preventive care	98	99	94	100	98	98	98
1.7.2 systematic preventive care	79	82	78	75	70	81	83
*1.7.3 education and information	99	99	98	100	98	100	99
1.7.4 local health programs	88	**79**	**96**	**100**	84	88	92
2.1 Rights and needs of patients	**97**	**96**	**98**	**98**	**94**	**97**	**99**
*2.1.1 respectful care	100	100	100	100	100	100	100
*2.1.2 right to privacy	100	100	100	100	100	100	100
*2.1.3 record confidentiality	99	98	100	100	96	100	100
*2.1.4 right to refuse treatment	100	100	100	100	100	100	100
*2.1.5 right to further opinion	100	100	100	100	100	100	100
*2.1.6 right to transfer from practice	100	100	100	100	100	100	100
*2.1.7 consent: clinical training	99	99	98	100	98	98	100
*2.1.8 consent: research programs	100	99	100	100	98	100	100
*2.1.9 acknowledges complaints	100	100	100	98	100	98	100
*2.1.10 privacy of accounts	100	100	100	100	100	100	100
3.1 Quality assurance & continuing education	**98**	**97**	**96**	**100**	**96**	**98**	**98**
*3.1.1 medical staff	99	99	98	100	98	98	100
3.1.2 staff involved in patient care	88	86	88	92	82	83	95
*3.1.3 administrative review	98	98	96	100	98	98	98
4.1 Practice staff	**97**	**96**	**98**	**98**	**92**	**100**	**98**
*4.1.1 person for practical help	97	96	98	98	92	100	98
*4.1.2 inter-personal skills	100	99	100	100	98	100	100
4.2 Medical records system	**92**	**94**	**88**	**94**	**90**	**91**	**95**
*4.2.1 comprehensive, well organised	95	96	90	98	96	94	95
*4.2.2 confidentiality	98	98	98	98	**94**	**98**	**100**
*4.2.3 transfer on request	100	100	100	98	100	98	100
*4.2.4 follow up abnormal results	99	100	98	98	94	100	100
4.3 Control of practice	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*4.3.1 clinical autonomy	100	100	100	100	100	100	100
5.1 Practice facilities	**79**	**77**	**80**	**83**	**68**	**77**	**88**
*5.1.1 one consultation room per doctor	100	100	100	100	100	100	100
*5.1.2 facilities in consultation room	100	99	100	100	98	100	100
5.1.3 waiting area	100	100	100	98	100	100	99
*5.1.4 toilets/hand washing facilities	99	**97**	**100**	**100**	98	97	100
*5.1.5 privacy for distressed	98	96	98	100	**94**	**97**	**100**
5.1.6 telecommunications system	98	99	96	96	98	98	96
5.1.7 medical & other records storage	100	99	100	100	98	100	100
5.1.8 practice security	94	97	92	92	**86**	**95**	**99**
*5.1.9 sterilisation, disinfection...	93	**93**	**90**	**98**	**84**	**95**	**98**
*5.1.10 contaminated waste disposal	84	83	84	85	75	84	88
*5.1.11 sharps disposal	98	98	96	98	96	98	98
5.1.12 safety of doctors & staff	93	93	94	92	**86**	**94**	**94**
*5.1.13 well maintained, visibly clean	99	98	100	100	98	98	100
5.2 Practice equipment	**77**	**80**	**74**	**73**	**76**	**75**	**78**
*5.2.1 medical equipment	99	98	100	98	**98**	**98**	**99**
*5.2.2 doctors bag	92	95	88	92	88	92	95
*5.2.3 vaccine storage	81	81	82	81	82	80	82
*5.2.4 equipment for procedures	100	100	100	100	100	100	100
5.2.5 resources and reference materials	94	95	96	92	92	95	95
5.3 Physical access	**100**	**99**	**100**	**100**	**98**	**100**	**100**
5.3.1 appropriate physical access	96	95	98	96	94	97	96
*5.3.2 off site visits (limited access)	100	99	100	100	98	100	100

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, = statistically significant.

Table 5.27 Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.1 Access and availability	**99**	**99**	**98**	**98**	**100**	**100**	**96**
*1.1.1 within two working days	99	99	98	100	100	100	98
*1.1.2 advice by telephone	100	100	100	100	100	100	100
*1.1.3 off site visits	100	100	100	100	100	100	100
*1.1.4 urgent matters	100	100	100	98	100	100	99
*1.1.5 24 hour cover	100	100	100	100	100	100	100
*1.1.6 flexible appointments system	100	100	100	100	100	100	100
1.2 The consultation and communication	**87**	**92**	**82**	**82**	**84**	**84**	**90**
1.2.1 practice information sheet	70	**71**	**64**	**75**	**65**	**67**	**75**
*1.2.2 consultation length	100	100	100	100	100	100	100
*1.2.3 risks of treatments	100	100	100	100	100	100	100
*1.2.4 substantial/unusual costs	99	99	98	100	98	98	100
*1.2.5 patients with different language	89	92	88	86	90	86	92
*1.2.6 health pamphlets and brochures	98	100	96	96	96	98	99
1.3 Diagnosis/manage. of health problems	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*1.3.1 consistency with wider profession	100	100	100	100	100	100	100
1.3.2 consistency within the practice	96	94	100	96	100	94	95
1.4 Content of medical records	**99**	**99**	**98**	**98**	**96**	**98**	**100**
*1.4.1 sufficient information	100	100	98	100	98	100	100
1.4.2 current health summary	84	83	84	88	88	86	81
*1.4.3 storage of non-active records	99	99	98	98	96	98	100
1.5 Continuity of care	**99**	**99**	**100**	**98**	**98**	**98**	**100**
*1.5.1 relevant standards	99	99	100	98	98	98	100
*1.5.2 doctor of choice	100	100	100	100	100	100	100
1.6 Integration of care	**100**	**99**	**100**	**100**	**98**	**100**	**100**
*1.6.1 knowledge/interaction	100	100	100	100	100	100	100
*1.6.2 referral letters	100	99	100	100	98	100	100
1.7 Health promotion...	**100**	**100**	**100**	**98**	**98**	**100**	**100**
*1.7.1 opportunistic preventive care	100	100	100	98	98	100	100
1.7.2 systematic preventive care	84	82	90	80	86	83	83
*1.7.3 education and information	100	100	100	100	100	100	100
1.7.4 local health programs	85	**79**	**88**	**94**	86	83	86
2.1 Rights and needs of patients	**91**	**95**	**88**	**86**	**86**	**94**	**92**
*2.1.1 respectful care	100	100	100	100	100	100	100
*2.1.2 right to privacy	100	100	100	100	100	100	100
*2.1.3 record confidentiality	100	100	100	100	100	100	100
*2.1.4 right to refuse treatment	100	100	100	100	100	100	100
*2.1.5 right to further opinion	100	100	100	100	100	100	100
*2.1.6 right to transfer from practice	100	100	100	100	100	100	100
*2.1.7 consent: clinical training	97	98	98	96	92	100	99
*2.1.8 consent: research programs	94	96	94	90	92	98	92
*2.1.9 acknowledges complaints	99	100	96	98	100	95	100
*2.1.10 privacy of accounts	100	100	100	100	100	100	100
3.1 Quality assurance & continuing education	**99**	**99**	**100**	**96**	**98**	**98**	**99**
*3.1.1 medical staff	100	100	100	98	98	100	100
3.1.2 staff involved in patient care	88	86	92	90	90	84	90
*3.1.3 administrative review	99	99	100	98	100	98	99
4.1 Practice staff	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*4.1.1 person for practical help	100	100	100	100	100	100	100
*4.1.2 inter-personal skills	100	100	100	100	100	100	100
4.2 Medical records system	**99**	**98**	**100**	**98**	**94**	**100**	**100**
*4.2.1 comprehensive, well organised	**100**	100	100	98	98	100	100
*4.2.2 confidentiality	100	100	100	100	100	100	100
*4.2.3 transfer on request	100	99	100	100	98	100	100
*4.2.4 follow up abnormal results	100	99	100	100	98	100	100
4.3 Control of practice	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*4.3.1 clinical autonomy	100	100	100	100	100	100	100
5.1 Practice facilities	**96**	**95**	**98**	**96**	**96**	**94**	**98**
*5.1.1 one consultation room per doctor	100	100	100	100	100	100	100
*5.1.2 facilities in consultation room	100	100	100	100	100	100	100
5.1.3 waiting area	100	100	100	100	100	100	100
*5.1.4 toilets/hand washing facilities	100	99	100	100	100	98	100
*5.1.5 privacy for distressed	99	98	100	98	98	97	100
5.1.6 telecommunications system	100	99	100	100	100	98	100
5.1.7 medical & other records storage	99	99	100	98	98	98	100
5.1.8 practice security	99	100	98	98	100	100	98
*5.1.9 sterilisation, disinfection...	**100**	99	100	100	100	98	100
*5.1.10 contaminated waste disposal	97	97	98	98	98	97	98
*5.1.11 sharps disposal	100	100	100	100	100	100	100
5.1.12 safety of doctors & staff	95	94	98	96	98	91	98
*5.1.13 well maintained, visibly clean	100	100	100	100	100	100	100
5.2 Practice equipment	**92**	**94**	**98**	**82**	**94**	**91**	**92**
*5.2.1 medical equipment	100	100	100	100	100	100	100
*5.2.2 doctors bag	98	99	100	94	98	97	99
*5.2.3 vaccine storage	94	95	98	88	96	94	93
*5.2.4 equipment for procedures	100	100	100	100	100	100	100
5.2.5 resources and reference materials	97	96	98	98	100	97	95
5.3 Physical access	**98**	**97**	**98**	**100**	**98**	**97**	**99**
5.3.1 appropriate physical access	99	98	100	100	100	98	99
*5.3.2 off site visits (limited access)	98	97	98	100	98	97	99

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, = statistically significant.

5.3.5 Reliability

Reliability refers to the "consistency of scores obtained by the same persons when re-examined with the same test on different occasions, or with different sets of equivalent items, or under other variable examining conditions".[88] A reliable measuring instrument behaves similarly under differing circumstances, producing similar results when administered by different people, at different times and using different forms. The reliability of the process of measuring standards used in the field test was measured by comparing the scores of joint with self assessment and principal with second surveyor. Joint and self assessment were also tested for internal reliability.

Reliability of the assessment tool

Joint assessment

A split-half reliability test was performed on joint assessment of criteria alone. The criteria were divided between two groups alternately, to obtain nearly equivalent halves. This resulted in 33 criteria being allocated to part one and 32 being allocated to part two.

The correlation between each half was 0.70. A reliability co-efficient of this magnitude indicates high reliability, however, this correlation is somewhat lower than is desirable for reliability coefficients, which usually fall in the 0.80 to 0.90 range. The value of Cronbach's α for part one was 0.51 and for part two was 0.54.

Self assessment

As with joint assessment, a split-half test was performed on self assessment alone, splitting the criteria alternately. Again, this resulted in the same 33 criteria being allocated to part one and 32 being allocated to part two.

The correlation between each half was 0.72. Values of Cronbach's α for part one was 0.47 and for part two was 0.53. Again, a reliability co-efficient of this magnitude indicates high reliability of the instrument.

The small difference in test scores between joint and self assessment does not indicate that self assessment was more reliable than joint assessment, it demonstrates that the test instrument itself was equally reliable when applied by practices or surveyors.

Reliability of assessment tool between assessors

The overall reliability of the field test may also be measured by the consistency in scores between the two surveyors and between self assessment and joint assessment.

Principal and second surveyors

A split-half reliability test was used in a test-re-test construct. The test (in this instance, the standards document) was administered by both principal and second surveyors, although rather than there being a test and a re-test both tests were administered simultaneously. The test was split so that the principal surveyors scores were contained in part one and the second surveyors scores were contained in part two.

The correlation between principal surveyor and second surveyor incorporating all criteria was 0.87. A reliability co-efficient of this magnitude falls between the desired range for reliability testing of 0.80 and 0.90 and indicates very high reliability for this measurement of standards. Values of Cronbach's α for the principal surveyor was 0.75 and for the second surveyor was 0.76. The Kappa statistic was 0.67 indicating substantial agreement between principal and second surveyor.

Reliability of the measurement of the standards between surveyors for individual criteria varied. This is reported under each of the criteria.

In terms of accreditation, reliability of outcome was also high as shown in Table 5.28.

Table 5.28 Reliability as measured by agreement between principal surveyor and second surveyor on accreditation - (numbers and percentages)

		Principal surveyor		
	n	Accredited	Not accredited	Total Col %
Second surveyor	Accredited	86	17	103 52.6
	Not accredited	15	78	93 47.4
	Total Row %	101 51.5	95 48.5	Agreement 83.7%

(k=0.67, substantial agreement)

Joint assessment and self assessment

A split-half reliability test was used in a test-re-test construct. The test (in this instance, the standards document) was administered by the practice (self assessment) and jointly by both principal and second surveyors (joint assessment).

The correlation between joint assessment and self assessment incorporating all criteria was 0.60. This shows that agreement between joint and self assessment is not as reliable as that of principal and second surveyor. The Values of Cronbach's α for joint assessment was 0.72 and for self assessment was also 0.72. Kappa statistic was 0.03 indicating only slight agreement.

Reliability of the measurement of the standards between joint and self assessment for individual criteria varied. This is reported under each of the criteria.

Table 5.29 Reliability as measured by agreement between self assessment and joint assessment on accreditation - (numbers and percentages)

		Self assessment		
	n	Accredited	Not accredited	Total Col %
Joint assessment	Accredited	77	32	109 55.6
	Not accredited	59	28	87 44.4
	Total Row %	136 69.4	60 30.6	Agreement 53.6%

(k=0.03, slight agreement)

In terms of accreditation, reliability as measured by agreement on accreditation was far higher between principal and second surveyor than it was between Joint and Self assessment (Table 5.29). There was 83.7% agreement between the individual surveyors on whether a practice would have been accredited compared to 53.6% agreement between Joint and Self Assessment.

Reliability of individual criteria

There were high levels of agreement between self assessment and joint assessment and between principal surveyor and second surveyor for most criteria. Reliability data for individual criteria are shown in Table 5.30.

For 60 (92%) of the 65 criteria agreement between principal and second surveyor was higher than agreement between joint and self assessment. This may be largely explained by the fact that joint and self assessment were carried out by different observers at different times whereas principal and

second surveyor assessment was carried out by different observers working together at the same time.

The range of agreement scores for self and joint assessment was 47% to 100%, while the range for principal and second surveyor was 72% to 100%.

In four cases agreement was equal for self/joint and principal/second. In one case agreement was higher for self/joint ("2.1.1 - The practice provides respectful care at all times and under all circumstances, with recognition of patient's personal dignity regardless of sex, age, religion, ethnicity, sexual preference or medical condition.").

For principal and second surveyor agreement was less than 80% on 11 criteria - discussion of substantial and unusual costs, awareness of interpreter services, consistency with the wider profession, sufficient information and health summaries in the medical records, opportunistic preventive care, knowledge of local health programs, obtaining patient consent for presence of trainee, staff training, safety of doctors and staff and vaccine storage. For each of these however agreement was over 70%. For self and joint assessment agreement was lower than 70% on 18 criteria.

In many cases poor agreement is accounted for by disagreement on whether a criterion was applicable or not rather than the degree of achievement on the criterion. In other cases poor agreement will have resulted from criteria being less than clear in their requirements.

Reliability of surveyor interpretation

While the field test did not measure the way in which surveyors were interpreting standards (for example, the sample size was too small to detect 'hard' vs 'soft' surveyors), observers reported that there was some variability between surveyors in their interpretation of criteria.

> *"The 'marking' of standards in these trials was very generous, easy, and slack. If someone else (such as the government) wished to 'mark' the practices more strictly ie. 'to the letter' - then quite different 'pass marks' would be obtained." (Surveyor, WA)*

> *"I am concerned that different surveyors differ markedly in their assessments. Most use a modicum of common sense in reaching a decision to approve something that does not fit precisely, but a minority will be pedantic and I believe unrealistic and inflexible. Care should be exercised that pedantic people be not teamed. Certainly that is a strong argument for two surveyors." (Surveyor, Qld)*

These issues will need to be addressed in the future as the accreditation process is developed.

Table 5.30 Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.1 Access and availability		
*1.1.1 within two working days	96	99
*1.1.2 advice by telephone	95	96
*1.1.3 off site visits	94	95
*1.1.4 urgent matters	77	87
*1.1.5 24 hour cover	89	94
*1.1.6 flexible appointments system	88	96
1.2 The consultation and communication		
1.2.1 practice information sheet	62	87
*1.2.2 consultation length	86	92
*1.2.3 risks of treatments	85	87
*1.2.4 substantial/unusual costs	61	75
*1.2.5 patients with different language	50	77
*1.2.6 health pamphlets and brochures	73	86
1.3 Diagnosis/manage. of health problems		
*1.3.1 consistency with wider profession	73	79
1.3.2 consistency within the practice	66	85
1.4 Content of medical records		
*1.4.1 sufficient information	56	75
1.4.2 current health summary	47	78
*1.4.3 storage of non-active records	81	88
1.5 Continuity of care		
*1.5.1 relevant standards	84	90
*1.5.2 doctor of choice	92	97
1.6 Integration of care		
*1.6.1 knowledge/interaction	92	92
*1.6.2 referral letters	74	82
1.7 Health promotion...		
*1.7.1 opportunistic preventive care	59	75
1.7.2 systematic preventive care	56	82
*1.7.3 education and information	61	80
1.7.4 local health programs	49	77
2.1 Rights and needs of patients		
*2.1.1 respectful care	100	99
*2.1.2 right to privacy	74	81
*2.1.3 record confidentiality	81	90
*2.1.4 right to refuse treatment	96	98
*2.1.5 right to further opinion	98	100
*2.1.6 right to transfer from practice	90	99
*2.1.7 consent: clinical training	54	77
*2.1.8 consent: research programs	62	88
*2.1.9 acknowledges complaints	79	95
*2.1.10 privacy of accounts	88	92
3.1 Quality assurance & continuing education		
*3.1.1 medical staff	89	97
3.1.2 staff involved in patient care	51	72
*3.1.3 administrative review	71	85
4.1 Practice staff		
*4.1.1 person for practical help	90	93
*4.1.2 inter-personal skills	95	97
4.2 Medical records system		
*4.2.1 comprehensive, well organised	74	88
*4.2.2 confidentiality	87	91
*4.2.3 transfer on request	95	99
*4.2.4 follow up abnormal results	84	88
4.3 Control of practice		
*4.3.1 clinical autonomy	94	94
5.1 Practice facilities		
*5.1.1 one consultation room per doctor	88	91
*5.1.2 facilities in consultation room	94	96
5.1.3 waiting area	91	96
*5.1.4 toilets/hand washing facilities	93	93
*5.1.5 privacy for distressed	91	97
5.1.6 telecommunications system	87	94
5.1.7 medical & other records storage	87	91
5.1.8 practice security	67	81
*5.1.9 sterilisation, disinfection...	74	86
*5.1.10 contaminated waste disposal	69	86
*5.1.11 sharps disposal	92	97
5.1.12 safety of doctors & staff	49	73
*5.1.13 well maintained, visibly clean	91	96
5.2 Practice equipment		
*5.2.1 medical equipment	92	95
*5.2.2 doctors bag	63	83
*5.2.3 vaccine storage	51	78
*5.2.4 equipment for procedures	96	96
5.2.5 resources and reference materials	51	80
5.3 Physical access		
5.3.1 appropriate physical access	72	84
*5.3.2 off site visits (limited access)	74	92

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria, ▭ = statistically significant

5.4 Individual Standards, Criteria and Indicators

Data in this section are presented in the following format:

- Section headings, standard numbers and titles, brief explanations, notes, footnotes, criterion numbers and titles, and indicator numbers and titles, are direct quotations from the Entry Standards.

- Practice compliance is reported as:

    - Percentage of practices which met the criterion (scored substantial, partial or not applicable) by joint and self assessment;

    - Percentage agreement between joint and self assessment and between principal and second surveyor at the level of substantial, partial, nil or not applicable (with comments where appropriate);

    - Differences in assessment in relation to RARA zone and practice size are detailed when significant.

- Assessment of criterion is reported as:

    - Percentages of practices and surveyors regarding the criterion as reflecting good practice, being acceptable or being achievable;

    - Differences in assessment of criterion in relation to RARA zone and practice size are detailed when significant.

- Comments on indicators by surveyors.

    - Comments by surveyors made at post Field Test workshops are included if the criterion was discussed at any workshop.

    - Suggested new criteria are quoted in bold.

- Numerical data related to each criterion is presented in tables at the end of each standard section together with the other criteria for that standard.

Section One: PRACTICE SERVICES

Standard 1.1 Access and availability

All patients are able to obtain timely care and advice appropriate to their needs.

Brief explanation: Comprehensive, whole patient care is only possible when a range of general practice services are both available and accessible.

Criterion ★1.1.1

Practice patients are normally able to obtain a consultation within two working days for non-urgent matters.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by both joint and self assessment (Table 1.1A). Agreement between joint and self assessment was 96%, and between principal and second surveyor 99% (Table 1.1B). Practices in rural and remote area (RARA) classifications 4&6 were less likely to score 'substantial achievement' by self assessment (χ^2 =10.31,df=4,p=0.04) (Table 1.1F). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.1C-F).

Assessment of criterion:

While this criterion was met by almost all practices participating in the Field Test, surveyors and practices appeared to find it less acceptable (Table 1.1H) and less a reflection of good practice (Table 1.1G) than most of the other criteria in the standards.

The criterion was regarded as reflecting good general practice by 88% of practices and 85% of surveyors. There were no differences by RARA classification or practice size (Table 1.1G). The criterion was acceptable to 81% of practices and 83% of surveyors, however rural practices were significantly less likely to agree that this criterion was acceptable (χ^2=9.12,df=2,p=0.01) (Table 1.1H). The criterion was seen as achievable by 92% of practices and 83% of surveyors. Both rural (χ^2=12.87,df=4,p=0.01) and large practices (χ^2=12.85,df=4,p=0.01) were less likely to regard this criterion as achievable (Table 1.1I).

Criterion 1.1.1 - Indicators:

☐ ***A. Staff confirm that patients are usually able to obtain a consultation within two working days for non-urgent matters (staff interview).***

☐ ***B. The appointments schedule can accommodate non-urgent patients within two working days (appointments schedule review).***

☐ ***C. Patients indicate that it is usually possible to obtain an appointment within two working days (patient survey)[1].***

Comments on Indicators by Surveyors:

The indicators were considered adequate for assessment of this criterion by the Field Test surveyors, although it was universally agreed that the patient survey question needed to more closely reflect the criterion. Field Test surveyors found the indicator relating to the appointments schedule to be most useful - "if the appointments book had blank appointments within two days you knew the criterion was met".

[1] Practices participating in field testing and trialing may be offered the option of carrying out a patient survey before they were visited. This data could be used as indicators to help surveyors determine the degree of achievement of criteria.

Criterion ★1.1.2

Practice patients are able to obtain information or advice related to their clinical care by telephone in a situation where a consultation is unnecessary or impractical.

Results for this criterion in the Field Test:

Practice compliance:

This criterion was substantially met by 98% and partially met by the remaining 2% of practices participating in the Field Test (Table 1.1E).

All practices met this criterion by each assessment method (Table 1.1A). Agreement between joint and self assessment was 95%, and between principal and second surveyor 96% (Table 1.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.1C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 92% of practices and surveyors. More practices from RARAs 3&5 disagreed with the statement that this reflected good general practice, compared to other practices (χ^2=10.15,df=4,p=0.04) (Table 1.1G). The criterion was acceptable to 84% of practices and 85% of surveyors (Table 1.1H) and was seen as achievable by 97% of practices and 92% of surveyors (Table 1.1I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 1.1.2 - Indicators:

☐ ***A. The doctor(s) takes or returns phone calls from patients when appropriate (doctor interview).***

☐ ***B. Staff responsible for answering telephones are aware of the doctor's policy on receiving and returning phone calls from patients and can describe how phone calls are triaged. (staff interview).***

☐ ***C. There is evidence of doctor/patient phone contact in the medical or other records (medical records review, documents and other records).***

☐ ***D. Patients indicate that they have been able to talk to a doctor on the telephone when appropriate (patient survey).***

Comments on Indicators by Surveyors:

Field Test surveyors suggested that almost all practices met this criterion based on the doctor interview, staff interview and patient survey indicators. Medical record review however suggested that less practices would meet this criterion if it was assessed by that method alone. Those without mention of telephone contact in the medical records were either not talking to patients on the telephone or, as suggested by the other three indicators, were talking to patients on the telephone but not entering this in their records.

Criterion ★1.1.3

Practice patients are normally able to obtain visits from a doctor (in their home, nursing home or hospital providing these are within a reasonable distance from the practice) for substantial medical reasons.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 1.1A). Agreement between joint and self assessment was 94%, and between principal and second surveyor 95% (Table 1.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.1C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 98% of practices and surveyors (Table 1.1G). The criterion was acceptable to 96% of practices and 95% of surveyors (Table 1.1H) and was seen as achievable by 99% of practices and 93% of surveyors (Table 1.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 1.1.3 - Indicators:

☐ ***A. The doctor(s) visits patients when appropriate (doctor interview).***

☐ ***B. Staff are aware of the doctor's policy on home or other visits and can describe situations in which a visit is appropriate (staff interview).***

☐ ***C. There is evidence of home or other visits in the medical records or appointment schedule (medical records review, appointment schedule review).***

☐ ***D. The doctors indicate what the practice has decided is a reasonable distance in terms of the area and types of problems (doctor interview).***

☐ ***E. The doctors can describe a few recent off-site visits and the reasons for the visits (doctor interview).***

☐ ***F. Patients indicate that they feel it is possible to obtain a home or other visit when necessary (patient survey).***

☐ ***G. The practice does not have any disincentives for home visits for substantial medical reasons (doctor interview, documents and other records).***

☐ ***H. The practice's billing records show evidence of home or other visits (documents and other records).***

Comments on Indicators by Surveyors:

Discussion of this criterion in the SA surveyor workshop suggested that it is difficult to assess with a patient survey because the expectations of patients and doctors differ considerably. It was also noted that patients who only receive visits outside the surgery would not be included in the survey under the current methodology, thus skewing the results against the practice. The workshop participants were of the opinion that this criterion could be satisfactorily assessed through the use of Medicare data.

Criterion ★1.1.4

A doctor is available to see patients for urgent medical matters.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion by each assessment method (Table 1.1A). Agreement between joint and self assessment was 77% and between principal and second surveyor 87% (Table 1.1B). There was a significant relationship between RARA and joint assessment, with practices in RARA 1&2 more likely to have 'substantially' than 'partially' met this criterion (χ^2=8.79,df=1,p<0.01) (Table 1.1E). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.1C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 1.1G). The criterion was acceptable to 99% of practices and 98% of surveyors (Table 1.1H) and was seen as achievable by all practices and surveyors (Table 1.1I). There were no significant differences in face validity, acceptability or achievability related to RARA practice size.

Criterion 1.1.4 - Indicators:

☐ ***A. Staff have been trained to recognise urgent medical matters (doctor interview).***

☐ ***B. Staff can describe urgent medical matters and procedures for obtaining urgent medical attention (staff interview).***

☐ ***C. Procedures for dealing with urgent medical matters are included in a staff manual, where one exists (documents and other records).***

Comments on Indicators by Surveyors:

These indicators were not discussed at the Surveyor Workshops.

Criterion ★1.1.5

The practice ensures reasonable 24 hour medical cover for practice patients.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 1.1A). Agreement between joint and self assessment was 89%, and between principal and second surveyor 94% (Table 1.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.1C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 98% of practices and 97% of surveyors (Table 1.1G). The criterion was acceptable to 92% of practices and 95% of surveyors (Table 1.1H) and was seen as achievable by 97% of practices and 86% of surveyors (Table 1.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 1.1.5 - Indicators:

☐ ***A. There is evidence of one of the following:***

(a) the practice doctor(s) provide(s) their own 24 hour cover either individually or through a roster of practice doctors; or

(b) an agreement with a nearby practice; or

(c) formal collaboration with a local hospital in rural areas; or

(d) an arrangement with a suitable deputising service (doctor interview, staff interview, documents and other records).

☐ ***B. Doctor(s) and staff can describe how patients are made aware of after hours arrangements (doctor interview, staff interview).***

☐ ***C. There is an appropriate after-hours message on an answering machine, where one exists. Alternatively, the practice has call diversion, a paging system or a mobile phone (direct observation).***

☐ ***D. The practice information sheet includes a section on after hours care arrangements (documents and other records).***

☐ ***E. Patients are satisfied that there is adequate 24 hour cover (patient survey).***

Comments on Indicators by Surveyors:

The NSW surveyor group suggested that the best indicator for this criterion would be a patient survey.

It was also agreed that indicator C (answering machine message) was a good indicator.

The Qld surveyor group discussed the certification or accreditation of medical deputising services. They suggested that an additional indicator might be documentation in the medical records of services provided by a deputising service.

Criterion ★1.1.6

There is a flexible appointments system[2] to accommodate patients with urgent problems and patients who need a longer consultation.

Results for this criterion in the Field Test:

Practice compliance:

All practices met this criterion by each assessment method (Table 1.1A). Agreement between joint and self assessment was 88%, and between principal and second surveyor 96% (Table 1.1B). For self assessment there was a relationship between RARA and performance on this criterion, 97% of practices from RARA 1&2 considering themselves to 'substantially' meet this criterion compared to 87% of practices from other areas (χ^2=7.07,df=1,p<0.01) (Table 1.1F). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.1C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 99% of practices and 97% of surveyors (Table 1.1G). The criterion was acceptable to 90% of practices and surveyors (Table 1.1H) and was seen as achievable by 98% of practices and 88% of surveyors (Table 1.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 1.1.6 - Indicators:

☐ ***A. The doctor(s) can describe how patients with urgent problems and those needing longer consultations are accommodated (doctor interview).***

☐ ***B. The staff can describe how patients with urgent problems and those needing longer consultations are accommodated within the practice's appointments system (staff interview).***

☐ ***C. The appointments schedule allows urgent cases and longer consultations (appointments schedule review).***

☐ ***D. Patients are satisfied with the practice's appointments system (patient survey).***

Comments on Indicators by Surveyors:

These indicators were not discussed in the Surveyor Workshops.

[2] This may include a drop-in system with adequate feedback to patients on anticipated waiting time.

Table 1.1A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
1.1 Access and availability				
*1.1.1 within two working days	100	99	100	100
*1.1.2 advice by telephone	100	100	100	100
*1.1.3 off site visits	99	100	99	99
*1.1.4 urgent matters	99	100	98	99
*1.1.5 24 hour cover	100	100	100	99
*1.1.6 flexible appointments system	100	100	100	99

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 1.1B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.1 Access and availability		
*1.1.1 within two working days	96	99
*1.1.2 advice by telephone	95	96
*1.1.3 off site visits	94	95
*1.1.4 urgent matters	77	87
*1.1.5 24 hour cover	89	94
*1.1.6 flexible appointments system	88	96

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 1.1C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.1 Access and availability	**98**	**97**	**98**	**98**	**94**	**98**	**99**
*1.1.1 within two working days	100	99	100	100	100	100	99
*1.1.2 advice by telephone	100	100	100	100	100	100	100
*1.1.3 off site visits	99	98	100	100	98	100	99
*1.1.4 urgent matters	99	98	100	98	96	98	100
*1.1.5 24 hour cover	100	100	98	100	98	100	100
*1.1.6 flexible appointments system	100	100	100	100	100	100	100

Table 1.1D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.1 Access and availability	**99**	**99**	**98**	**98**	**100**	**100**	**96**
*1.1.1 within two working days	99	99	98	100	100	100	98
*1.1.2 advice by telephone	100	100	100	100	100	100	100
*1.1.3 off site visits	100	100	100	100	100	100	100
*1.1.4 urgent matters	100	100	100	98	100	100	99
*1.1.5 24 hour cover	100	100	100	100	100	100	100
*1.1.6 flexible appointments system	100	100	100	100	100	100	100

Table 1.1E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.1 Access and availability							
*1.1.1 within two working days	98	99	98	96	100	98	96
*1.1.2 advice by telephone	98	99	96	98	100	95	99
*1.1.3 off site visits	96	94	98	98	96	98	94
*1.1.4 urgent matters	87	**93**[1]	**82**	**79**	84	86	89
*1.1.5 24 hour cover	94	93	92	93	95	90	96
*1.1.6 flexible appointments system	95	94	94	98	96	89	99

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, [1] Practices in RARA 1&2 were statistically more likely to have 'substantially' than 'partially' met this criterion compared to other practices (χ^2=8.79,df=1,p<0.01).

Table 1.1F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.1 Access and availability							
*1.1.1 within two working days	96	**99**	**96**	**92**[1]	100	98	93
*1.1.2 advice by telephone	96	98	92	96	100	95	94
*1.1.3 off site visits	94	94	96	94	94	94	95
*1.1.4 urgent matters	86	84	82	94	90	82	87
*1.1.5 24 hour cover	93	92	96	94	94	91	95
*1.1.6 flexible appointments system	92	**97**[2]	**88**	**86**	96	91	90

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, [1] Practices in RARA 4&6 were statistically less likely to score 'substantial achievement' by self assessment (χ^2 =10.31,df=4,p=0.04), [2] practices from RARA 1&2 were more likely to consider themselves to have 'substantially' met this criterion than practices from other areas,(χ^2=7.07,df=1,p<0.01).

Table 1.1G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.1 Access and availability								
*1.1.1 within two working days	85	88	90	84	88	93	93	82
*1.1.2 advice by telephone	92	92	**94**	**89**[1]	**93**	92	89	95
*1.1.3 off site visits	98	99	100	98	98	98	100	99
*1.1.4 urgent matters	100	99	99	100	100	98	100	100
*1.1.5 24 hour cover	97	98	98	96	100	93	98	100
*1.1.6 flexible appointments system	97	99	100	96	100	95	100	100

More practices from RARAs 3&5 disagreed with the statement that this reflected good general practice, compared to other practices (χ^2=10.15,df=4,p=0.04).

Table 1.1H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.1 Access and availability								
*1.1.1 within two working days	83	81	**90**	**74**[1]	**71**[1]	88	85	75
*1.1.2 advice by telephone	85	84	87	77	85	73	87	87
*1.1.3 off site visits	95	96	96	95	98	93	96	99
*1.1.4 urgent matters	98	99	98	100	100	98	99	100
*1.1.5 24 hour cover	95	92	92	95	90	85	91	97
*1.1.6 flexible appointments system	90	90	93	84	90	85	87	94

[1] Rural practices (RARA 3-6) were significantly less likely to agree that this criterion was acceptable (χ^2=9.12,df=2,p=0.01).

Table 1.1I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.1 Access and availability								
*1.1.1 within two working days	83	92	**99**	**87**[1]	**85**[1]	**100**	**96**	**85**[1]
*1.1.2 advice by telephone	92	97	98	93	100	98	94	99
*1.1.3 off site visits	93	99	100	98	98	98	100	99
*1.1.4 urgent matters	100	100	100	100	100	100	100	100
*1.1.5 24 hour cover	86	97	95	100	98	95	96	99
*1.1.6 flexible appointments system	88	98	100	98	95	98	98	99

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, [1] Both rural (RARA 3-6) (χ^2=12.87,df=4,p=0.01) and large practices (4+) (χ^2=12.85,df=4,p=0.01) were less likely to regard this criterion as achievable.

Standard 1.2: The consultation and communication

The practice provides the opportunity for patients to communicate their health problems and concerns and receive an appropriate response.

Brief explanation: ***The consultation is the focus of the delivery of general practice care. Patient satisfaction with the consultation is a significant contributor to quality care. A key determinant of patient satisfaction is the quality of communication occurring during the consultation and the amount of information provided to patients.***[3]

Criterion: 1.2.1

The practice provides patients with written information about the practice.

Results for this criterion in the Field Test:

Practice compliance:

By joint assessment 51% of practices failed to meet this criterion compared to just 30% by self assessment (χ^2=17.68,df=2,p<0.01) (Table 1.2A). Agreement between joint and self assessment was 62%, and between principal and second surveyor 87% (Table 1.2B). By joint assessment practices with four doctors or more met this criterion 70% of the time compared to practices with fewer doctors which met it 33% of the time (χ^2=28.72,df=2,p<0.01) (Table 1.2C). For self assessment there was a significant relationship between level of achievement and RARA (χ^2=13.89,df=6,p=0.03). This was largely a result of the differences between 'substantially' and 'partially' meeting this criteria between practices from RARAs 3&5 and other practices (Table 1.2 D&F). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.2C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 74% of practices and 80% of surveyors. Practices with fewer than four doctors were less likely to agree that this reflected good practice. Only 62% of practices with less than four doctors agreed that this reflected good practice compared to 88% of large practices, (χ^2=13.63,df=2,p<0.01) (Table 1.2G). The criterion was acceptable to 54% of practices and 71% of surveyors. It was less acceptable to practices with fewer than four doctors, 68% of large practices believing this was acceptable compared to 43% of smaller practices (χ^2=10.4,df=2,p<0.01).(Table 1.2H). The criterion was seen as achievable by 83% of surveyors and 81% of practices (Table 1.2I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criteria: 1.2.1 - Indicators:

☐ ***A. There is a practice information sheet including name(s) of doctor(s), access arrangements, phone numbers, consulting hours, emergency and after hours arrangements*** **(documents and other records)*****. (A photocopied, typed A4 information sheet would be quite acceptable).***

☐ ***B. The practice information sheet is freely available to patients*** **(direct observation)*****.***

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

The NSW surveyor group felt that the indicators were too detailed, arguing that it could be simply stated that "there is a practice information sheet showing relevant information." The Vic group, on the other hand, strongly argued that the criterion, as it stood, should be essential - "it is easy to produce, patients respond well to it and it represents good management. You are stupid if you haven't got one!"

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[3] See, for example, Williams, S. and Calnan, M. Key determinants of consumer satisfaction with general practice. Family Practice. 1991 Sep; 8(3): 237-42.

The SA group suggested that while a patient information sheet was important it should not be essential in a set of minimum standards as it was basically an educational tool and, like criterion 1.1.1, could be "fully assessed by patients".

Criterion★1.2.2

Consultation times are long enough to allow quality care. This means that <u>average</u> times are not less than 10 minutes. Actual time for individual appointments will vary according to clinical need.

Results for this criterion in the Field Test:

<u>Practice compliance</u>:

Almost all practices met this criterion by each assessment method (Table 1.2A). Agreement between joint and self assessment was 86%, and between principal and second surveyor 92%. (Table 1.2B). Practices with four or more doctors were more likely by joint assessment to achieve a rating of 'substantial' (98%) compared to other practices (88%) (χ^2=7.32,df=1,p<0.01) (Table 1.2E). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.2C-F).

<u>Assessment of the criterion</u>:

The criterion was regarded as reflecting good general practice by 89% of practices and 90% of surveyors (Table 1.2G). The criterion was acceptable to 81% of practices and 86% of surveyors (Table 1.2H) and was seen as achievable by 78% of surveyors and 95% of practices (Table 1.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★1.2.2 - Indicators:

☐ ***A. The average number of patients seen by each doctor in a four hour session does not exceed 24*** **(appointments schedule review).**

☐ ***B. After each consultation the doctor routinely checks that the patient believes that their needs have been met and that the patient has understood the doctor's advice*** **(doctor interview, patient survey).**

☐ ***C. Patients feel that they have not been rushed when having a consultation*** **(patient survey).**

☐ ***D. Patients report that their condition is discussed enough with them and that words and explanations used by the doctor are easy to understand*** **(patient survey).**

☐ ***E. Other (specify) .....***

Note:	There will obviously be circumstances under which this will not be possible, for example during the winter cold epidemic or in areas where there is a low doctor/patient ratio (eg. many rural areas). Any assessment of this criterion should be based on common sense, taking into account the specific circumstances of the practice. Consultation times of this length have been shown to be associated with more communication between patient and doctor, more health promotion, higher patient satisfaction and reduced stress for GPs. For example, Ridsdale, L., Carruthers, M., Morris, R., and Ridsdale, J. Study of the effect of time availability on the consultation. <u>Journal of the Royal College of General Practitioners</u>. 1989 Dec; 39(329):488-91.

<u>Comments on Indicators by Surveyors:</u>

Three groups wanted to discuss this criterion. The WA and Vic groups were concerned about how it

can be adequately assessed while some surveyors in the SA group had problems with the criterion itself.

Some members of the Vic group suggested that this criterion is difficult to assess when using indicator A (appointments book) because it is "easy to fudge". The same view was expressed in the WA group.

The problem of differences between doctors was also raised. The question was asked, "what is acceptable for the practice as a whole and what do you do if there is one outlier?" The consensus appeared to be that it would be unfair to fail a large practice where only one doctor is not meeting the criterion. The point was made however that practices (including every doctor) should have to meet this criterion if it is considered important (which it was by most surveyors).

Criterion★1.2.3

Patients attending the practice are informed of the risks associated with treatments or investigations proposed by their GP.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 1.2A). Agreement between joint and self assessment was 85%, and between principal and second surveyor 87% (Table 1.2B). For joint assessment practices from RARAs 1&2 were more likely to achieve the higher rating of 'substantial' (94%) than were other practices (84%) (χ^2=5.52,df=1,p=0.02) (Table 1.2E). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.2C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 96% of practices and 95% of surveyors (Table 1.2G). The criterion was acceptable to 91% of practices and 83% of surveyors (Table 1.2H) and was seen as achievable by 81% of surveyors and 96% of practices (Table 1.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★1.2.3 - Indicators:

☐ ***A. The doctor(s) can describe the ways in which patients are given the opportunity to discuss the risks and benefits of proposed treatments or investigations*** **(doctor interview)*.***

☐ ***B. The doctor(s) can describe how they use leaflets, brochures or written information to support their explanation of conditions to patients when appropriate*** **(doctor interview)*.***

☐ ***C. Patients are not discouraged from asking questions and are satisfied that they have received enough information from the doctor*** **(patient survey)*.***

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

No comments were made on these indicators at any of the surveyor workshops.

Criterion★1.2.4

Patients attending the practice are given an indication of any substantial or unusual costs of treatments or investigations initiated by the doctor.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion by each assessment method (Table 1.2A). Agreement

between joint and self assessment was 61%, and between principal and second surveyor 75% (Table 1.2B). For joint assessment practices from RARAs 1&2 were more likely to achieve ratings of 'substantial' compared to 'partial' (80%) than were other practices (60%) (χ^2=8.65,df=1,p<0.01) (Table 1.2E). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.2C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 88% of practices and 82% of surveyors (Table 1.2G). The criterion was acceptable to 77% of practices and 64% of surveyors (Table 1.2H) and was seen as achievable by 67% of surveyors and 90% of practices (Table 1.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ✭1.2.4 - Indicators:

☐ ***A. The doctor(s) can describe the ways in which patients who have been referred to another practice are advised about billing procedures at that practice or, where billing procedures at such practices are unknown, the doctor(s) can confirm that patients are advised to check for themselves*** **(doctor interview).**

☐ ***B. The doctor(s) can describe the ways in which patients are advised of any substantial or unusual costs that may be involved in proposed treatments or investigations*** **(doctor interview).**

☐ ***C. The practice fees are clearly displayed within the practice*** **(direct observation).**

☐ ***D. Patients indicate that they have received adequate information about practice fees*** **(patient survey).**

☐ ***E. The practice information sheet includes information about practice fees*** **(documents and other records).**

☐ ***F. Other (specify) .....***

Note:	The intent of this criterion is to ensure that patients have some idea of what their out of pocket expenses may be. For example, a patient referred to a non bulk-billing specialist from a bulk-billing practice should be given some indication of what sort of fees are involved, or should at least be advised to check. This is not to say that doctors should know what each test or treatment will cost, but they should indicate that there may be a cost. It is, of course, the responsibility of other health care providers to give patients an indication of the costs of any treatments or investigations that they order.

Comments on Indicators by Surveyors:

It was generally agreed by surveyors that this criterion was difficult to measure because it combined two issues - costs within the practice and costs of referrals. It was concluded that the latter was the cause of this criterion's lack of support among many Field Test participants.

Surveyors were later shown the Standards Reference Group's (SRG) suggested improvements to this criterion in which it was split into two criteria:

Information about the costs of consultations, treatments and investigations commonly undertaken within the practice is readily available to patients.

Patients attending the practice are advised about the possibility of substantial or unusual costs associated with referrals.

There was universal support amongst surveyors for this suggestion, with a majority arguing that the

first (practice costs) should be essential, while the second (costs associated with referrals) should be non-essential.

It was worrying that many surveyors were under the misapprehension that practices were expected to have a detailed knowledge of how much a particular specialist charges for a variety of services. This misunderstanding would probably account for the relatively low level of acceptability amongst Field Test participants.

There was a suggestion from the Qld group that the second new criterion should read:

Patients attending the practice are advised to check about the possibility of substantial or unusual costs associated with referrals.

The Qld group also suggested that an indicator for this new criterion could be something like "The practice leaflet includes advice to patients to check with specialists to whom they have been referred about what their treatments and investigations will cost and how they will be billed."

Most surveyors agreed that the original criterion was difficult to assess using the patient survey.

Criterion★1.2.5

The practice has appropriate strategies for dealing with patients whose first language is different from that of the practice medical staff.

Results for this criterion in the Field Test:

Practice compliance:

Over 89% of practices met this criterion for each assessment method (Table 1.2A). Excluding those who considered this to be 'not applicable' all practices would have met this criteria by joint assessment compared to 63% by self assessment (χ^2=91.88,df=1,p<0.01) (Table 1.2A). For both joint and self assessment there was a strong relationship between RARA and the opinion that this criterion was 'not applicable' (Table 1.2 E&F). There was a significant relationship between practice size and assessment of this criterion by joint assessment, although this tended to indicate that small practices felt this to be 'not applicable' (Table 1.2E). Agreement between joint and self assessment was 50%, and between principal and second surveyor 77%. (Table 1.2B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.2C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by over 84% of practices and surveyors (Table 1.2G). The criterion was acceptable to 70% of practices and 83% of surveyors (Table 1.2H) and was seen as achievable by 79% of surveyors and 72% of practices (Table 1.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★1.2.5 - Indicators:

☐ ***A. The doctor(s) and staff are aware of the availability and methods of access to interpreter services*** **(doctor interview, staff interview).**

☐ ***B. The doctor(s) and staff can describe how they manage patients who speak a different language eg. allowing patients to choose between using an interpreter service or using family members and friends*** **(doctor interview, staff interview).**

☐ ***C. The doctor(s) can describe circumstances in which using family members and friends to interpret may be inappropriate*** **(doctor interview).**

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

Surveyors in the Field Test often rated this criterion as 'not applicable' if the practice reported never

(or very rarely) seeing non-English speaking patients. This point was made in the Vic group where it was observed that rural practices do not regularly encounter persons without proficiency in English, thus rendering this criteria 'not applicable'.

In most groups the surveyors were critical of the availability of interpreter services, particularly telephone interpreters.

A majority of surveyors felt that the indicators (and the criterion itself) did not adequately describe what was required of practices. It was agreed that it was necessary to make the requirements more explicit. The Vic group suggested that the indicators could be reorganised in a more logical order; B, C, A.

There was a general consensus that this criterion should probably be down-graded to non-essential (although this was not unanimous), reflecting the inherent difficulties in both measuring and meeting the criterion in its current form, but recognising its importance in educating practices about the issue.

It was acknowledged that patient input would be very valuable in assessment but difficult to obtain.

Surveyors were shown the SRG's proposed amendment to Criterion 1.2.5:

The practice has appropriate strategies for communicating with patients who do not speak English or who are much more proficient in another language.

All the groups supported the SRG's amendments to the criterion, but pointed out that these amendments did not address the fundamental problems with the criterion, which is that it lacks specificity in its requirements and that there are systemic problems in meeting it.

Criterion★1.2.6

The practice stocks an appropriate range of the many health pamphlets and brochures about common and serious conditions (such as asthma and diabetes) available from Departments of Health and other organisations. The practice also stocks information provided by local community organisations, support and self-help groups. These information brochures should be available in those languages most reasonably to be expected from the practice population, if readily available.

Results for this criterion in the Field Test:

Practice compliance:

Over 97% of practices met this criterion by each assessment method (Table 1.2A). Agreement between joint and self assessment was 73%, and between principal and second surveyor 86%. (Table 1.2B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.2C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 87% of practices and 78% of surveyors (Table 1.2G) and was acceptable to 77% of practices and 71% of surveyors. Practices from RARA 3&5 (27%) were more likely to 'disagree' (rather than 'agree' or 'don't know') with the proposition that this criterion was acceptable than other practices (9%) (χ^2=6.86,df=1,p<0.01) (Table 1.2H). The criterion was seen as achievable by 90% of surveyors and 94% of practices (Table 1.2I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★1.2.6 - Indicators:

☐ ***A. There is a range of posters, leaflets and brochures freely available or on display in the waiting room, reception and/or consulting rooms. Where appropriate these are available in other languages*** **(direct observation)*.***

☐ ***B. There is a range of leaflets and brochures available in each consultation room*** **(direct observation)*.***

☐ ***C. The doctor(s) can describe how they use leaflets, brochures or written information to support their explanation of conditions to patients when appropriate*** **(doctor interview).**

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

Many surveyors observed that the vast majority of brochures and pamphlets are below standard - "80% of pamphlets are crap!" and that they tend to be strewn all over the waiting room.

Surveyors conceded that pamphlets were nevertheless a good idea, and all groups preferred the SRG's amended wording of Criterion 1.2.6:

Practice patients are able to readily access a range of written information about common and serious conditions and relevant community organisations, support and self-help groups.

Two of the groups suggested down-grading the criterion to non-essential, while the others did not discuss whether the status of the criterion should be changed.

Table 1.2A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
1.2 The consultation and communication				
1.2.1 practice information sheet	**49**[1]	**70**[1]	51	53
*1.2.2 consultation length	100	100	100	100
*1.2.3 risks of treatments	100	100	100	100
*1.2.4 substantial/unusual costs	99	99	97	97
*1.2.5 patients with different language	**100**	**89**[2]	99	100
*1.2.6 health pamphlets and brochures	98	98	96	99

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria, [1] Significantly less practices met this criteria by joint assessment compared to self assessment (χ^2=17.68,df=2,p<0.01). [2] Excluding those who considered this to be 'not applicable' only 63% of practices would have met this criteria by self assessment compared to 100% by joint assessment (χ^2=91.88,df=1,p<0.01).

Table 1.2B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.2 The consultation and communication		
1.2.1 practice information sheet	62	87
*1.2.2 consultation length	86	92
*1.2.3 risks of treatments	85	87
*1.2.4 substantial/unusual costs	61	75
*1.2.5 patients with different language	50	77
*1.2.6 health pamphlets and brochures	73	86

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 1.2C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.2 The consultation and communication	**96**	**98**	**92**	**96**	**94**	**95**	**98**
1.2.1 practice information sheet	49	50	50	48	**32**	**36**	**70**[1]
*1.2.2 consultation length	100	100	98	100	100	98	100
*1.2.3 risks of treatments	100	100	98	100	100	100	99
*1.2.4 substantial/unusual costs	99	99	98	98	98	98	99
*1.2.5 patients with different language	100	100	100	100	100	100	100
*1.2.6 health pamphlets and brochures	98	99	96	98	96	98	99

[1] Practices with four doctors or more met this criterion more frequently than practices with fewer doctors (χ^2=28.72,df=2,p<0.01).

Table 1.2D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.2 The consultation and communication	**87**	**92**	**82**	**82**	**84**	**84**	**90**
1.2.1 practice information sheet	70	**71**	**64**[1]	**75**	65	67	75
*1.2.2 consultation length	100	100	100	100	100	100	100
*1.2.3 risks of treatments	100	100	100	100	100	100	100
*1.2.4 substantial/unusual costs	99	99	98	100	98	98	100
*1.2.5 patients with different language	89	92	88	86	90	86	92
*1.2.6 health pamphlets and brochures	98	100	96	96	96	98	99

[1] There was a significant relationship between level of achievement and RARA (χ^2=13.89,df=6,p=0.03). This was largely a result of the differences between 'substantially' and 'partially' meeting this criteria between practices from RARAs 3&5 and other practices.

Table 1.2E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.2 The consultation and communication							
1.2.1 practice information sheet	41	40	42	42	24	28	61
*1.2.2 consultation length	91	94	90	88	**88**	**86**	**98**[1]
*1.2.3 risks of treatments	88	**94**[2]	**82**	**83**	84	91	89
*1.2.4 substantial/unusual costs	68	**79**[3]	**54**	**60**	74	72	61
*1.2.5 patients with different language	67	**76**[4]	**68**[4]	**49**[4]	**62**[5]	**63**[5]	**71**[5]
*1.2.6 health pamphlets and brochures	79	84	68	79	78	81	77

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Practices with four or more doctors were more likely to achieve a rating of 'substantial' for this criterion (χ^2=7.32,df=1,p<0.01). [2] For this criterion practices from RARAs 1&2 were more likely to achieve the higher rating of 'substantial' than were other practices (χ^2=5.52,df=1,p=0.02). [3] For this criterion practices from RARAs 1&2 were more likely to achieve ratings of 'substantial' compared to 'partial' than were other practices (χ^2=8.65,df=1,p<0.01). [4] There was a strong relationship between RARA and the opinion that this criterion was 'not applicable'. [5] There was a significant relationship between practice size and assessment of this criterion as a result of many small practices rating it as 'not applicable'.

Table 1.2F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.2 The consultation and communication							
1.2.1 practice information sheet	46	**52**[1]	**46**[1]	**35**[1]	37	39	58
*1.2.2 consultation length	91	95	86	88	92	89	92
*1.2.3 risks of treatments	92	95	88	90	92	90	93
*1.2.4 substantial/unusual costs	57	66	47	49	52	59	59
*1.2.5 patients with different language	47	**55**[2]	**50**[2]	**27**[2]	48	41	51
*1.2.6 health pamphlets and brochures	75	75	71	80	68	78	77

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] There was a significant relationship between level of achievement and RARA (χ^2=13.89,df=6,p=0.03). [2] There was a strong relationship between RARA and the opinion that this criterion was 'not applicable'.

Table 1.2G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.2 The consultation and communication								

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.2.1 practice information sheet	80	74	80	64	71	**59**[1]	**66**[1]	**88**
*1.2.2 consultation length	90	89	92	85	88	86	85	93
*1.2.3 risks of treatments	95	96	95	96	98	88	96	100
*1.2.4 substantial/unusual costs	82	88	89	82	93	81	91	90
*1.2.5 patients with different language	85	85	92	76	80	85	81	87
*1.2.6 health pamphlets and brochures	78	87	90	82	86	84	85	90

[1] Practices with fewer than four doctors were less likely to agree that this criterion reflected good practice (χ^2=13.63,df=2,p<0.01).

Table 1.2H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.2 The consultation and communication								
1.2.1 practice information sheet	71	54	59	48	50	**43**[1]	**43**[1]	**68**
*1.2.2 consultation length	86	81	83	80	78	80	82	81
*1.2.3 risks of treatments	83	91	94	84	93	85	91	94
*1.2.4 substantial/unusual costs	64	77	79	67	82	72	74	82
*1.2.5 patients with different language	83	70	76	59	67	74	62	72
*1.2.6 health pamphlets and brochures	71	77	**84**	**68**[2]	**73**	75	72	82

[1] This criterion was less acceptable to practices with fewer than four doctors, (χ^2=10.4,df=2,p<0.01). [2] Practices from RARA 3&5 were more likely to 'disagree' that this criterion was acceptable than other practices (χ^2=6.86,df=1,p<0.01).

Table 1.2I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.2 The consultation and communication								
1.2.1 practice information sheet	83	81	84	76	80	69	79	88
*1.2.2 consultation length	78	95	95	93	98	95	93	97
*1.2.3 risks of treatments	81	96	96	98	95	92	100	96
*1.2.4 substantial/unusual costs	67	90	91	92	85	88	93	89
*1.2.5 patients with different language	79	72	79	68	62	74	60	80
*1.2.6 health pamphlets and brochures	90	94	94	91	95	93	93	95

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Standard 1.3 Diagnosis and management of specific health problems

In order to promote high standards of care the practice reaches broad agreement on approaches to diagnosis, management and outcomes which are consistent with relevant RACGP, state and national guidelines.

***Brief explanation:* Practices have a responsibility to ensure that they are employing up to date methods for diagnosis and management that are broadly consistent with those of other Australian general practitioners.**

Criterion:★1.3.1

The practice ensures that its approaches to common and serious conditions are broadly consistent with approaches adopted by the wider profession.

Practice compliance:

Over 98% of practices met this criterion by each assessment method (Table 1.3A). Agreement between joint and self assessment was 74%, and between principal and second surveyor 79% (Table 1.3B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.3C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 1.3G). The criterion was acceptable to 98% of practices and 93% of surveyors and was seen as achievable by 90% of surveyors and 99% of practices (Table 1.3I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion:★1.3.1 - Indicators:

☐ ***A. The doctor(s) can describe how they ensure that their approaches to common and serious conditions are broadly consistent with approaches adopted by the wider profession*** **(doctor interview).**

☐ ***B. There is a selection of state and national guidelines available within the practice, eg. the National Asthma Management Plan and the National Consensus Conference on Hypertension statement*** **(direct observation).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

The NSW surveyor group suggested that measurement of this criterion could be improved by the addition of an indicator such as "there is evidence in the medical records that the practice provides care consistent with that provided by most GPs." The group expressed some concern over the medico-legal issues associated with this criterion and urged the SRG to examine these carefully. The group was concerned about where the line is drawn between acceptable and unacceptable practice.

It was suggested that indicator B (state and national guidelines) was too proscriptive and should be loosened.

Criterion 1.3.2

Group practices ensure consistency within themselves of diagnosis and management of common and serious conditions.

Practice compliance:

Over 95% of practices met this criterion for each assessment method (Table 1.3A). Agreement between joint and self assessment was 66%, and between principal and second surveyor 85% (Table 1.3B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.3C-F).

.Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 92% of practices and 87% surveyors. Practices from RARAs 3&5 were more likely to 'disagree' with the statement that this reflected good general practice than were other practices (χ^2=11.84,df=4,p=0.02) (Table 1.3G). The criterion was acceptable to 82% of practices and 83% of surveyors (Table 1.3H) and was seen as achievable by 81% of surveyors and 94% of practices (Table 1.3I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 1.3.2 - Indicators:

☐ ***A. The doctors in a group practice can describe how they ensure consistency, within the practice, of diagnosis and management of common and serious conditions*** **(doctor interview).**

☐ ***B. There is a regular clinical meeting*** **(doctor interview).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

Some SA surveyors had misunderstood this criterion, believing that it required all doctors to "be the same". Both the SA and WA groups suggested that the wording could be improved to more clearly reflect the intent of the criterion, which is that patients do not receive conflicting advice within a practice. Neither had any suggestions for improved wording however.

The SA group suggested that indicator B (clinical meetings) needed to state what was required, for example a weekly meeting.

Table 1.3A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
1.3 Diagnosis/manage. of health problems				
*1.3.1 consistency with wider profession	98	100	98	98
1.3.2 consistency within the practice	96	96	95	96

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 1.3B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.3 Diagnosis/manage. of health problems		
*1.3.1 consistency with wider profession	73	79
1.3.2 consistency within the practice	66	85

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 1.3C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.3 Diagnosis/manage. of health problems	**98**	**97**	**100**	**98**	**96**	**98**	**99**
*1.3.1 consistency with wider profession	98	97	100	98	96	98	99
1.3.2 consistency within the practice	96	96	94	98	n/a	92	98

n/a = not applicable

Table 1.3D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.3 Diagnosis/manage. of health problems	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*1.3.1 consistency with wider profession	100	100	100	100	100	100	100
1.3.2 consistency within the practice	96	94	100	96	n/a	94	95

Table 1.3E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.3 Diagnosis/manage. of health problems							
*1.3.1 consistency with wider profession	79	75	82	83	80	72	83
1.3.2 consistency within the practice	56	57	60	52	n/a	64	77

Table 1.3F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.3 Diagnosis/manage. of health problems							
*1.3.1 consistency with wider profession	90	91	90	88	92	89	89
1.3.2 consistency within the practice	46	47	46	44	n/a	50	64

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 1.3G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.3 Diagnosis/manage. of health problems								
*1.3.1 consistency with wider profession	100	99	99	100	100	100	100	99
1.3.2 consistency within the practice	87	92	**93**	**82**[1]	**100**	88	94	92

[1] Practices from RARAs 3&5 were more likely to 'disagree' with the statement that this criterion reflected good general practice than were other practices (χ^2=11.84,df=4,p=0.02).

Table 1.3H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.3 Diagnosis/manage. of health problems								
*1.3.1 consistency with wider profession	93	98	96	100	98	98	96	99
1.3.2 consistency within the practice	83	82	82	71	93	82	82	82

Table 1.3I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.3 Diagnosis/manage. of health problems								
*1.3.1 consistency with wider profession	90	99	99	98	100	100	100	97
1.3.2 consistency within the practice	81	94	95	85	100	97	94	92

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Standard 1.4 Content of medical records

Patient medical records contain sufficient information to identify the patient, and document assessment, management, progress and outcomes.

<u>Brief explanation:</u> Adequate medical records are essential for maintaining continuity of care, professional development and medico-legal protection.

The content of medical records is a clinical matter and so is included under Practice Services. The system of records used is an administrative concern and is therefore included under Practice Administration.

Criterion:★1.4.1

The medical records contain sufficient information to allow another doctor to carry on the management of practice patients.

Results for this criterion in the Field Test:

<u>Practice compliance</u>:

Over 92% of practices met this criterion by each assessment method (Table 1.4A). Agreement between joint and self assessment was 56%, and between principal and second surveyor 75% (Table

1.4B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.4C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 99% of practices and 100% of surveyors (Table 1.4G). The criterion was acceptable to 97% of practices and 95% of surveyors (Table 1.4H) and was seen as achievable by 63% of surveyors and 95% of practices (Table 1.4I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★1.4.1 - Indicators:

☐ ***A. Each medical record includes:-***

(I) a note of every doctor/patient encounter;

(ii) reason for encounter;

(iii) the diagnosis, where appropriate;

(iv) the management plan (including, where necessary, expected date of review); and

***(v) prescribed medication (including strength, directions for use and number of repeats)* (medical records review).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

The NSW surveyor group suggested that indicator A should be modified to read "*A random selection of* medical records include, for each record, a note of every doctor/patient encounter... etc." While this would be a much clearer description of what the surveyors were actually measuring, if adopted the change would need to be reflected throughout the standards document.

The WA group felt that the detail included between the brackets in indicator A (relating to the detail needed in each record) should be removed, and suggested that the criterion should read:

The medical records contain sufficient information in a form accessible to another doctor.

Criterion 1.4.2

The patient's individual medical record includes a current health summary.

Results for this criterion in the Field Test:

Practice compliance:

Between 16% and 40% of practices did not meet this criterion for each assessment method. By self assessment 16% of practices failed this criterion compared to 40% by joint assessment (χ^2=27.07,df=1,p<0.01) (Table 1.4A). Agreement between joint and self assessment was 47%, and between principal and second surveyor 78% (Table 1.4B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.4C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by over 93% of practices and surveyors. Practices from RARAs 3&5 were more likely to 'disagree' (14%) with the statement that this reflected good practice compared with less than 2% of other practices (χ^2=8.87,df=1,p<0.01) (Table 1.4G). The criterion was acceptable to 80% of practices and 78% of surveyors (Table 1.4H) and was seen as achievable by 46% of surveyors and 79% of practices (Table 1.4I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size

of practice.

Criterion 1.4.2 - Indicators:

☐ ***A. The records of 50% of patients with ongoing medical problems contain a health summary*** **(medical records review).**

☐ ***B. Each health summary includes a social and family history, past problems, active problems, allergies and sensitivities, medication, immunisations and management*** **(medical records review).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

Surveyors agreed that this criterion represented good practice and was one of the best discriminators between 'good' and 'bad' practices. Many felt that the criterion should be essential, although a majority argued that this was unrealistic in 1995.

The surveyors suggested that it would be useful for the assessment protocol to have a check list of items that should appear in the summary so that areas that are being met can be ticked off.

Some surveyors observed that practices often overestimated how well they achieved this criterion. It was felt that smaller practices would find this deficiency easier to rectify than larger practices which would be more daunted by it - "a larger practice would need a marathon strategy to update 'old' patients."

The Vic group suggested that a new essential criterion could be something like "the practice medical records have provision for the inclusion of health summaries". This would encourage practices to begin the process of incorporating health summaries without requiring them all to be completed as an entry standard.

Indicator A was criticised by many surveyors because "there was no clear definition of an on-going problem". Other criticism related to the level being set at 50% of patients with on-going problems, although many of those expressing this worry had mistakenly assumed that this meant 50% of all records.

Some surveyors also felt that a definition of a *current* health summary was required.

Criterion★1.4.3

Non-active medical records are kept and stored by the practice.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion by each assessment method (Table 1.4A). Agreement between joint and self assessment was 81%, and between principal and second surveyor 88% (Table 1.4B). A significant association was observed between size of practice and joint assessment of this criteria. Practices with less than four doctors did not perform as well as other practices or regarded this as 'not applicable' (χ^2=13.67,df=6,p=0.03) (Table 1.4E). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.4C-F).

Assessment of the criterion:

The criterion was regarded as reflecting good general practice by 95% of practices and surveyors (Table 1.4G). The criterion was acceptable to 86% of practices and 97% of surveyors (Table 1.4H) and was seen as achievable by 91% of surveyors and 97% of practices (Table 1.4I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ✭1.4.3 - Indicators:

☐ ***A. Individual medical records are kept for a minimum of seven years from the point of last contact with the patient*** **(medical records review).**

☐ ***B. 'Non-active' medical records are stored in a safe place*** **(direct observation).**

☐ ***C. Records for patients who have not been seen for more than one year are marked with a throw-out date and stored safely, although some practices may choose (and it is preferable) to keep records indefinitely*** **(medical records review).**

☐ ***D. Records of minors are kept until the date of their 25th birthday*** **(medical records review).**

☐ ***E. When transferring records to another practice either the original record or a photocopy of the original is kept by the practice*** **(medical records review).**

☐ ***F. Other (specify) .....***

Note:	These indicators come from a state government act on limitations, which established that time frame for bringing an action for damages for personal injuries.

Comments on Indicators by Surveyors:

Several Qld surveyors felt that a definition of "safe place" was necessary for indicator B. Otherwise there was general agreement with the indicators.

Table 1.4A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
1.4 Content of medical records				
*1.4.1 sufficient information	93	100	92	91
1.4.2 current health summary	**61**[1]	**84**	60	64
*1.4.3 storage of non-active records	99	99	99	100

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criterion. [1] Significantly more practices failed this criterion by joint assessment compared to self assessment (χ^2=27.07,df=1,p<0.01).

Table 1.4B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.4 Content of medical records		
*1.4.1 sufficient information	56	75
1.4.2 current health summary	47	78
*1.4.3 storage of non-active records	81	88

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criterion.

Table 1.4C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.4 Content of medical records	**93**	**93**	**92**	**94**	**86**	**95**	**95**
*1.4.1 sufficient information	93	94	92	93	86	97	95
1.4.2 current health summary	61	60	60	65	64	63	58
*1.4.3 storage of non-active records	99	98	100	98	96	98	100

Table 1.4D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.4 Content of medical records	**99**	**99**	**98**	**98**	**96**	**98**	**100**
*1.4.1 sufficient information	100	100	98	100	98	100	100
1.4.2 current health summary	84	83	84	88	88	86	81
*1.4.3 storage of non-active records	99	99	98	98	96	98	100

Table 1.4E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.4 Content of medical records							
*1.4.1 sufficient information	62	67	50	65	62	61	63
1.4.2 current health summary	26	24	24	33	32	22	27
*1.4.3 storage of non-active records	87	84	90	92	**78**[1]	**84**[1]	**95**

[1] Practices with less than four doctors did not perform as well as other practices on this criterion or regarded it as 'not applicable' (χ^2=13.67,df=6,p=0.03).

Table 1.4F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.4 Content of medical records							
*1.4.1 sufficient information	82	83	78	83	84	78	83
1.4.2 current health summary	40	38	30	54	55	40	31
*1.4.3 storage of non-active records	84	82	82	90	78	87	86

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 1.4G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.4 Content of medical records								
*1.4.1 sufficient information	100	99	100	98	98	98	100	99
1.4.2 current health summary	98	93	**96**	**84**[1]	**98**	93	93	94
*1.4.3 storage of non-active records	95	95	94	93	98	88	96	97

[1] Practices from RARAs 3&5 were more likely to disagree with the statement that this criterion reflected good practice compared with other practices (χ^2=8.87,df=1,p<0.01).

Table 1.4H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.4 Content of medical records								
*1.4.1 sufficient information	95	97	99	93	98	98	94	99
1.4.2 current health summary	78	80	83	72	83	70	81	86
*1.4.3 storage of non-active records	97	86	87	74	98	76	87	90

Table 1.4I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.4 Content of medical records								
*1.4.1 sufficient information	63	95	94	91	90	95	91	92
1.4.2 current health summary	46	79	81	74	81	87	68	83
*1.4.3 storage of non-active records	91	97	96	96	100	98	98	96

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Standard 1.5 Continuity of care

The practice makes all reasonable provisions for continuity of care.

<u>Brief explanation</u>: Continuity of care allows patients to develop a relationship with their doctor over time. Doctors who know their patients are better able to provide high quality, comprehensive, whole patient care, including effective health promotion and early detection strategies.

Continuity is enhanced by GPs coordinating individual patient care within the health system and communicating with doctors and other health workers.

Patients have a significant role in facilitating continuity of care. The aim of this standard is to ensure that patients have the opportunity of receiving continuity of care.

Criterion:★1.5.1

The practice demonstrates its commitment to continuity of care through:-

	Relevant Standards
a. being available and accessible	***1.1***
b. developing agreed approaches on diagnosis and management	***1.3***
c. using adequate medical records	***1.4; 4.2***
d. acting as coordinator within the health system	***1.6***
e. employing health promotion and risk reduction strategies	***1.7***

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 1.5A). Agreement between joint and self assessment was 84%, and between principal and second surveyor 90% (Table 1.5B). On joint assessment, solo practices were less likely to score 'substantial' on this criterion (76%) compared to other practices (93%) (χ^2=9.64,df=1,p<0.01), although no solo practice failed to meet it (Table 1.5E). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.5C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 99% of practices and 100% of surveyors (Table 1.5G). The criterion was acceptable to 98% of practices and 100% of surveyors (Table 1.5H) and was seen as achievable by 90% of surveyors and 100% of practices (Table 1.5I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion:★1.5.1 - Indicators:

☐ ***A. The practice meets the standards specified above.***

☐ ***B. The practice has a number of long-term patients, where long-term is defined relative to the life of the practice*** **(medical records review, patient survey)*.***

☐ ***C. The practice has policies or strategies which encourage continuity of care*** **(doctor interview)*.***

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

Some of the Qld surveyors said they had difficulty measuring this criterion, noting that indicator B (medical records review) was most useful.

Cross referencing to other standards was seen as cumbersome by some surveyors.

Criterion:★1.5.2

Patients attending group practices are usually able to see the doctor of their choice, if available.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 1.5A). Agreement between joint and self assessment was 92%, and between principal and second surveyor 97% (Table 1.5B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.5C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 96% of practices and surveyors (Table 1.5G). The criterion was acceptable to 89% of practices and 93% of surveyors (Table 1.5H) and was seen as achievable by 90% of surveyors and 95% of practices. Practices in RARA 4&6 (χ^2=8.84,df=1,p<0.01) and solo practices (χ^2=4.52,df=1,p=0.03) were less likely than other practices to consider this criterion achievable (Table 1.5I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion: ★1.5.2 - Indicators:

☐ ***A. Staff can describe how patients, when making an appointment or attending the practice, are able to request their preferred doctor, if they have one*** **(staff interview).**

☐ ***B. Staff give patients a brief explanation if their preferred doctor is not available and tell them when he/she will be available*** **(staff interview).**

☐ ***C. The appointments schedule clearly differentiates between appointments for each doctor*** **(appointments schedule review).**

☐ ***D. Patients are free to see the doctor of their choice for follow-up visits*** **(staff interview, patient survey).**

☐ ***E. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion at any of the surveyor workshops.

Table 1.5A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
1.5 Continuity of care				
*1.5.1 relevant standards	100	99	100	100
*1.5.2 doctor of choice	100	100	100	100

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 1.5B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.5 Continuity of care		
*1.5.1 relevant standards	84	90
*1.5.2 doctor of choice	92	97

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 1.5C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.5 Continuity of care	**100**	**100**	**98**	**100**	**100**	**98**	**100**
*1.5.1 relevant standards	100	100	98	100	100	98	100
*1.5.2 doctor of choice	100	100	100	100	n/a	100	100

Table 1.5D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.5 Continuity of care	**99**	**99**	**100**	**98**	**98**	**98**	**100**
*1.5.1 relevant standards	99	99	100	98	98	98	100
*1.5.2 doctor of choice	100	100	100	100	n/a	100	100

Table 1.5E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.5 Continuity of care							
*1.5.1 relevant standards	88	87	92	87	**76[1]**	**95**	**90**
*1.5.2 doctor of choice	77	79	82	69	n/a	95	100

[1] On joint assessment, solo practices were less likely to score 'substantial' on this criterion compared to other practices (χ^2=9.64,df=1,p<0.01).

Table 1.5F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.5 Continuity of care							
*1.5.1 relevant standards	93	91	96	96	92	92	95
*1.5.2 doctor of choice	77	77	80	77	n/a	95	99

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion, n/a = not applicable.

Table 1.5G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.5 Continuity of care								
*1.5.1 relevant standards	100	99	99	100	100	100	98	100
*1.5.2 doctor of choice	97	99	100	98	100	100	98	100

Table 1.5H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.5 Continuity of care								
*1.5.1 relevant standards	100	98	96	98	100	98	98	97
*1.5.2 doctor of choice	93	89	92	84	90	88	91	89

Table 1.5I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.5 Continuity of care								
*1.5.1 relevant standards	90	100	100	100	100	100	100	100
*1.5.2 doctor of choice	90	95	**99**	**95**	**87[1]**	**82[2]**	**100**	**94**

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Practices in RARA 4&6 were less than other practices to consider this achievable (χ^2=8.84,df=1,p<0.01). [2] Solo practices were less likely than other practices to regard the criterion as achievable (χ^2=4.52,df=1,p=0.03).

Standard 1.6 Integration of care

The practice works with a range of other health and community services in its area to improve individual patient care.

Brief explanation: ***General practices can help patients make optimum use of the full range of health services available in the community. This requires well-developed channels of communication between general practices and other health workers, community health services and hospitals.***

Criterion:★1.6.1

The practice demonstrates knowledge of and interaction with appropriate health and community services in its area to facilitate optimal patient care.

Results for this criterion in the Field Test:

Practice compliance:

All practices substantially or partially met this criterion by each assessment method (Table 1.6A). Agreement between joint and self assessment on the level of compliance was 92%, and between principal and second surveyor also 92% (Table 1.6B). For self assessment, practices in RARA 3&5 were more likely to achieve a rating of 'substantial' rather than 'partial' than practices in other RARA groups (χ^2=6.00,df=1,p=0.01) (Table 1.6F). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.6C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 97% of practices and surveyors (Table 1.6G). The criterion was acceptable to 90% of practices and 88% of surveyors (Table 1.6H) and was seen as achievable by 85% of surveyors and 99% of practices (Table 1.6I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion:★1.6.1 - Indicators:

☐ ***A. The doctor(s) can describe a variety of local medical services such as diagnostic services, hospitals and consultant services*** **(doctor interview)*.***

☐ ***B. The doctor(s) can describe a variety of local allied health services (eg. physiotherapists etc.)*** **(doctor interview)*.***

☐ ***C. The doctor(s) can describe a variety of local community, social and other health services (eg. self help groups etc.)*** **(doctor interview)*.***

☐ ***D. The doctor(s) can describe their interaction with a variety of local services*** **(doctor interview)*.***

☐ ***E. The doctor(s) and staff can describe the practice procedures for referral to consultants, diagnostic and community health and other community services*** **(doctor interview, staff interview)*.***

☐ ***F. Directories for referrals are available for locums etc. when necessary*** **(documents and other records)*.***

☐ ***G. There is evidence that the practice works with appropriate health services*** **(medical records review, documents and other records).**

☐ ***H. Other (specify) .....***

Comments on Indicators by Surveyors:

The SA surveyor group suggested that this criterion be split into two - knowledge and interaction with health services (essential) and knowledge and interaction with community services (non-essential).

Criterion:★1.6.2

All patients being referred have an appropriate referral letter. In the case of an emergency or other unusual circumstance a telephoned referral may be appropriate.

Results for this criterion in the Field Test:

Practice compliance:

Over 96% of practices met this criterion for each assessment method. (Table 1.6A). Agreement between joint and self assessment was 74%, and between principal and second surveyor 82% (Table 1.6B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.6C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 96% of practices and surveyors (Table 1.6G). The criterion was acceptable to 96% of practices and 95% of surveyors (Table 1.6H) and was seen as achievable by 83% of surveyors and 99% of practices (Table 1.6I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion:★1.6.2 - Indicators:

☐ ***A. Referral letters:***

a. are legible (and preferably typed);

b. contain relevant background social information and history;

c. contain problem, key examination findings and current treatment;

d. include reason for referral and expectation of referral;

e. are on appropriate practice stationery - plain paper or practice letterhead is considered 'appropriate stationery'. Routine use of drug company notepads is considered unacceptable **(documents and other records, doctor interview, staff interview)*.***

☐ ***B. Other (specify) .....***

> **Note:** There is a considerable body of evidence showing that problems exist with communication between GPs and other medical practitioners. See for example, Montalto, M.; Harris, P. and Rosengarten, P. Survey of Australian emergency physicians' expectations of general practitioner referrals. British Journal of General Practice. 1993,43:277-280.

Comments on Indicators by Surveyors:

It was pointed out by most surveyors that verification of this criterion is difficult unless copies of letters are retained by practices. There was considerable discussion at each of the workshops about whether practices should be required to keep copies of referral letters as part of the standards. Surveyors were fairly evenly divided on the issue across the country, with some arguing that many referral letters (eg. those for refraction) contain little of value and would simply take up space in practice files. It was suggested by one of the groups that all referral letters, "except those for routine review" should be kept. This led to a discussion (unresolved) about what was or was not routine.

It was noted that keeping referral letters is probably becoming a medico-legal necessity and is in any case useful as they can be both educational and a defacto health summary.

The Vic group suggested that an additional indicator for this criterion could be that the doctors have the appropriate proforma pads for preparing referral letters. The SA group suggested that if practices pass this criterion without the surveyors seeing any letters (ie. on the basis of staff and doctor interviews only) then this fact should be recorded as part of their assessment.

It was also suggested that the criterion could be rewritten to say "All patients being referred to another practice have an appropriate referral.", dropping the word "letter".

Table 1.6A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
1.6 Integration of care				
*1.6.1 knowledge/interaction	100	100	100	100
*1.6.2 referral letters	97	100	98	97

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 1.6B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.6 Integration of care		
*1.6.1 knowledge/interaction	92	92
*1.6.2 referral letters	74	82

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 1.6C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.6 Integration of care	**98**	**99**	**94**	**98**	**96**	**97**	**99**
*1.6.1 knowledge/interaction	100	100	100	100	100	100	100
*1.6.2 referral letters	97	99	94	98	96	97	99

Table 1.6D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.6 Integration of care	**100**	**99**	**100**	**100**	**98**	**100**	**100**
*1.6.1 knowledge/interaction	100	100	100	100	100	100	100
*1.6.2 referral letters	100	99	100	100	98	100	100

Table 1.6E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.6 Integration of care							
*1.6.1 knowledge/interaction	97	95	98	100	94	97	99
*1.6.2 referral letters	78	78	68	87	70	82	78

Table 1.6F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.6 Integration of care							
*1.6.1 knowledge/interaction	95	**93**[1]	**100**	**94**[1]	94	94	96
*1.6.2 referral letters	93	92	92	94	92	94	93

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Practices in RARAs 1&2 AND 4&6 were less likely to achieve a rating of 'substantial' rather than 'partial' than practices in RARA 3&5 (χ^2=6.00,df=1,p=0.01).

Table 1.6G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.6 Integration of care								
*1.6.1 knowledge/interaction	100	98	98	96	100	95	98	99
*1.6.2 referral letters	97	99	98	100	100	100	96	100

Table 1.6H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.6 Integration of care								
*1.6.1 knowledge/interaction	88	90	91	89	88	83	93	92
*1.6.2 referral letters	95	96	94	96	100	95	93	99

Table 1.6I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.6 Integration of care								
*1.6.1 knowledge/interaction	85	99	98	100	100	98	100	99
*1.6.2 referral letters	83	99	99	98	100	97	100	99

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Standard 1.7 Health promotion, risk reduction & prevention of disease

The practice provides health promotion and disease prevention services. These are based on scientifically validated guidelines whenever possible.

Brief explanation: Over 80% of Australians see a general practitioner at least once a year.[4] This provides doctors with a unique opportunity for health promotion, risk reduction and preventive strategies.

Criterion ★1.7.1

The practice provides opportunistic preventive care and early case detection using scientifically validated guidelines where appropriate.

Results for this criterion in the Field Test:

Practice compliance:

Over 97% of practices met this criterion for each assessment method (Table 1.7A). Agreement between joint and self assessment was 59%, and between principal and second surveyor 75% (Table 1.7B). Practices from RARAs 3&5 were less likely to be rated as 'substantial' (46%) than practices from other RARAs for joint assessment (χ^2=9.34,df=2,p<0.01) (Table 1.7E). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.7C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 97% of practices and surveyors (Table 1.7G). The criterion was acceptable to 88% of practices and 91% of surveyors (Table 1.7H) and was seen as achievable by 78% of surveyors and 96% of practices (Table 1.7I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★1.7.1 - Indicators:

☐ ***A. Patient medical records include brief information about risk factors such as smoking, alcohol consumption, family history etc.*** **(medical records review).**

[4] Deeble, J. Medical Services through Medicare. National Health Strategy, Background Paper No. 2, February 1991 (Page 30).

☐ ***B. The doctor(s) can describe the opportunities for health promotion and disease prevention presented by a range of common patient problems*** **(doctor interview)*.***

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

The WA and Qld surveyor groups reported that they found this criterion difficult to assess. One surveyor commented: "This is the honour system, the doctor interview is all you have to go on."

A discussion ensued in WA as to whether the criterion and its indicators should be considerably tightened to make it more 'measurable'. It was concluded that the criterion should remain in its current form and was better measured by a 'reasonable peer' exercising a judgment than by having a long list of specific and detailed requirements.

The WA group also suggested that an indicator be added covering immunisation.

Criterion 1.7.2

The practice provides systematic preventive care and early case detection using scientifically validated guidelines where appropriate and systematically encourages participation in preventive activities subject to patient consent.

Results for this criterion in the Field Test:

Practice compliance:

Only 79% of practices met this criterion by joint assessment and 84% by self assessment (Table 1.7A). Agreement between joint and self assessment was 56%, and between principal and second surveyor 82% (Table 1.7B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.7C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 86% of practices and 90% of surveyors (Table 1.7G). The criterion was acceptable to 73% of practices and 67% of surveyors (Table 1.7H) and was seen as achievable by only 58% of surveyors and 81% of practices. Practices from RARA 1&2 (90%) were more likely to report this to be an achievable criterion than other practices (73%) (χ^2=10.39,df=2,p<0.01) (Table 1.7I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 1.7.2 - Indicators:

☐ ***A. There should be one of the following:***

> ***(a) card based system showing due dates for preventive activities*** **(documents and other records, direct observation)*; or***
>
> ***(b) systematic flagging of medical records for opportunistic preventive activities*** **(medical records review)*; or***
>
> ***(c) a register of patients for reminder/recall for preventive activities*** **(documents and other records, direct observation)*; or***
>
> ***(d) a computerised recall system*** **(direct observation)*.***

☐ ***B. The practice utilises recall systems offered by other agencies, eg. local pathology services or government Pap smear registers*** **(documents and other records)*.***

☐ ***C. Other (specify) .....***

Note:	See, for example, Guidelines for Preventive Activities in General Practice, (Red Book, 2nd edition 1993) designed by the RACGP Preventive and Community Medicine Committee.

	Preventive activities should be scientifically validated. Examples of scientifically validated activities are blood pressure checks, immunisation, mammography in women over 50 and Pap smears.

Comments on Indicators by Surveyors:

It was generally agreed by surveyors that this criterion should remain non-essential (one SA surveyor strongly dissenting). Many surveyors expressed concerns about their increasing legal requirements as GPs. It was felt in the Qld group that this criterion may give lawyers more ammunition against GPs. There was an observation that general practice should guard against becoming too paternalistic, and patients should take increased responsibility for their own health. One comment from a Victoria surveyor was that this sort of standard was "akin to dentists having to phone all their patients every night to say have you brushed your teeth tonight?".

The NSW group struggled with the definition of "systematic", asking "what does it mean?".

The Qld group suggested an additional indicator that "there is evidence in the medical records that [for example] blood pressure is regularly checked".

Surveyors in several groups thought that the indicators were good but that the criterion was too wordy. An alternative wording of the criterion suggested by the Vic group was: "The practice systematically encourages participation in preventative activities subject to patient consent".

This was similar in spirit to a suggestion made in SA that all words in the criterion after "detection" be removed.

Criterion ★1.7.3

The practice provides education and information to patients on how to *(sic)* ***they can prevent illness and improve their own health.***

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 1.7A). Agreement between joint and self assessment was 61%, and between principal and second surveyor 80% (Table 1.7B). For joint assessment solo practices were more likely to be rated 'partial' (40%) than other practices (χ^2=8.00,df=2,p<0.02) (Table 1.7E). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.7C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 93% of practices and surveyors (Table 1.7G). The criterion was acceptable to 85% of practices and 89% of surveyors (Table 1.7H) and was seen as achievable by 93% of surveyors and 80% of practices (Table 1.7I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★1.7.3 - Indicators:

☐ ***A. The practice has a range of health promotion information materials and resources*** **(direct observation)*.***

☐ ***B. There is evidence in the patient medical records that education and counselling on illness prevention is provided to patients*** **(medical records review)*.***

☐ ***C. Patients report that they have discussed illness prevention with their doctor*** **(patient survey)*.***

☐ ***D. The doctor(s) can describe how they educate and counsel their patients on illness prevention*** **(doctor interview)*.***

☐ ***E. The practice uses posters and brochures in the waiting room to encourage health promotion*** **(direct observation).**

☐ ***F. Other (specify) .....***

Comments on Indicators by Surveyors:

There was no discussion of these indicators at any of the surveyor workshops.

Criterion 1.7.4

The practice identifies and cooperates with recognised local health promotion and public health programs.

Results for this criterion in the Field Test:

Practice compliance:

Over 84% of practices met this criterion for each assessment method (Table 1.7A). Agreement between joint and self assessment was 49%, and between principal and second surveyor 77%. (Table 1.7B). When practices met this criterion, they were more likely to be rated as having 'substantially' met it by joint assessment (79%) compared with self assessment (58%) (χ^2=17.08,df=1,p<0.01) (data not shown). For both joint and self assessment practices in RARA 1&2 were more likely to fail this criterion. Twenty one percent of practices from RARAs 1&2 failed by both joint and self assessments compared to 2% of other practices by joint assessment (χ^2=20.89,df=1,p<0.01) and 9% by self assessment (χ^2=6.00,df=1,p=0.01) (data not shown). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 1.7C-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 90% of practices and surveyors (Table 1.7G). The criterion was acceptable to 68% of practices and 73% of surveyors (Table 1.7H) and was seen as achievable by 63% of surveyors and 92% of practices (Table 1.7I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 1.7.4 - Indicators:

☐ ***A. The doctor(s) can describe local health promotion programs, if any, and indicate how they have cooperated with programs they have determined to be appropriate*** **(doctor interview).**

☐ ***B. The doctor(s) can describe how they provide health education to community groups*** **(doctor interview).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

The indicators were generally thought to be useful although limited in scope, with the following improvements suggested:

(i) the NSW group suggested that indicator A be reworded to read "There is evidence that the practice is involved in local health promotion programs..."

(ii) the SA group felt that very few practices would actually meet indicator B. They suggested that it be changed to read "The doctor(s) can describe how they provide or refer patients to community groups for health education."

(iii) some surveyors felt there should be more indicators suggesting how the criterion could be met, although they did not have any suggestions.

Table 1.7A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
1.7 Health promotion...				
*1.7.1 opportunistic preventive care	98	100	96	97
1.7.2 systematic preventive care	79	84	77	82
*1.7.3 education and information	99	100	99	100
1.7.4 local health programs	88	85	88	88

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 1.7B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
1.7 Health promotion...		
*1.7.1 opportunistic preventive care	59	75
1.7.2 systematic preventive care	56	82
*1.7.3 education and information	61	80
1.7.4 local health programs	49	77

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 1.7C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.7 Health promotion...	**98**	**99**	**92**	**100**	**98**	**98**	**96**
*1.7.1 opportunistic preventive care	98	99	94	100	98	98	98
1.7.2 systematic preventive care	79	82	78	75	70	81	83
*1.7.3 education and information	99	99	98	100	98	100	99
1.7.4 local health programs	88	**79**[1]	**96**	**100**	84	88	92

[1] Practices from RARAs 1&2 failed more frequently to meet this criterion than other practices (χ^2=20.89,df=1,p<0.01).

Table 1.7D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.7 Health promotion...	**100**	**100**	**100**	**98**	**98**	**100**	**100**
*1.7.1 opportunistic preventive care	100	100	100	98	98	100	100
1.7.2 systematic preventive care	84	82	90	80	86	83	83
*1.7.3 education and information	100	100	100	100	100	100	100
1.7.4 local health programs	85	**79**[1]	**88**	**94**	86	83	86

[1] Practices from RARAs 1&2 failed more frequently to meet this criterion than other practices (χ^2=6.00,df=1,p=0.01).

Table 1.7E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.7 Health promotion...							
*1.7.1 opportunistic preventive care	61	**65**	**46**[1]	**71**	64	69	54
1.7.2 systematic preventive care	36	39	30	37	32	34	41
*1.7.3 education and information	74	77	66	75	**58**[2]	**84**	**75**
1.7.4 local health programs	**68**[3]	58	70	85	56	66	76

[1] Practices from RARAs 3&5 were less likely to be rated as 'substantial' than practices from other RARAs (χ^2=9.34,df=2,p<0.01). [2] Solo practices were more likely to be rated 'partial' than other practices for this criterion (χ^2=8.00,df=2,p<0.02). [3] When practices met this criterion, they were more likely to be rated as having 'substantially' met it by joint assessment compared with self assessment (χ^2=17.08,df=1,p<0.01)

Table 1.7F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
1.7 Health promotion...							
*1.7.1 opportunistic preventive care	78	79	76	78	80	72	81
1.7.2 systematic preventive care	32	32	36	29	35	22	39
*1.7.3 education and information	74	76	68	76	78	69	75
1.7.4 local health programs	**49**[1]	41	52	61	44	47	53

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] When practices met this criterion, they were more likely to be rated as having 'substantially' met it

by joint assessment compared with self assessment (χ^2=17.08,df=1,p<0.01)

Table 1.7G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.7 Health promotion...								
*1.7.1 opportunistic preventive care	98	98	99	98	98	95	98	100
1.7.2 systematic preventive care	90	86	90	79	86	83	83	90
*1.7.3 education and information	93	97	98	93	98	98	94	97
1.7.4 local health programs	90	92	93	87	95	85	96	92

Table 1.7H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.7 Health promotion...								
*1.7.1 opportunistic preventive care	88	91	90	93	88	93	87	92
1.7.2 systematic preventive care	67	73	78	69	65	72	74	72
*1.7.3 education and information	85	89	90	86	90	93	85	90
1.7.4 local health programs	68	73	74	68	74	62	81	72

Table 1.7I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
1.7 Health promotion...								
*1.7.1 opportunistic preventive care	78	96	99	94	93	98	94	96
1.7.2 systematic preventive care	58	81	**90**[1]	**75**	**71**	83	83	80
*1.7.3 education and information	80	93	94	93	90	95	93	92
1.7.4 local health programs	63	92	92	89	95	80	98	93

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

[1] Practices from RARA 1&2 were more likely to report this to be an achievable criterion than other practices (χ^2=10.39,df=2,p<0.01).

Section Two: RIGHTS AND NEEDS OF PATIENTS

Standard 2.1 Respect for the rights and needs of patients.

The practice ensures that the doctor(s) and staff respect the rights and needs of patients.

<u>Brief explanation:</u> Confidentiality, privacy and ethical behaviour are crucial. Practices which respect these rights maintain confidence in the profession and increase patients' willingness to communicate fully with their doctor.

While it should also be recognised that patients have certain responsibilities[5] in relation to their health care, practices can only be assessed on their recognition of the rights of patients.

Criterion★2.1.1

The practice provides respectful care at all times and under all circumstances, with recognition of patients' personal dignity regardless of sex, age, religion, ethnicity, sexual preference or medical condition.

Results for this criterion in the Field Test:

<u>Practice compliance:</u>

Almost all practices met this criterion by each assessment method (Table 2.1A). Agreement between joint and self assessment was 100%, and between principal and second surveyor 99% (Table 2.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

[5] Those interested in the responsibilities of patients may consult, for example, <u>Consumer Health Rights, A summary of your health rights and responsibilities</u> (Consumers' Health Forum of Australia, Canberra, reprint 1992) or <u>The ACHS Accreditation Guide. Standards for Australian Healthcare Facilities</u> (Australian Council on Healthcare Standards. ACHS July 1991).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by all practices and surveyors (Table 2.1G). The criterion was acceptable to 98% of practices and 97% of surveyors. However while 8% of solo practices considered this criterion to be unacceptable, it was acceptable to all other practices (χ^2=8.84,df=1,p<0.01) (Table 2.1H). The criterion was seen as achievable by 97% of surveyors and 99% of practices. (Table 2.1I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★2.1.1 - Indicators:

☐ ***A. No new patient is ever refused access to a practice doctor on the basis of their sex, age, religion, ethnicity, sexual preference or medical condition.*** **(doctor interview, staff interview).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

Several Vic surveyors commented that in one instance a practice turned away a man, because it only treated female patients. The group discussed this case, concluding that this was unacceptable for a general practice. It was agreed that practitioners should be allowed to turn people away based on other considerations (eg too many patients), so long as the reasons were not as defined in criterion 2.1.1. The criterion was supported without amendment.

The difficulties of measuring this criterion using a patient survey were also discussed. Surveyors felt that patients who had had bad experiences in relation to this criterion would be unlikely to continue attending the practice and therefore be unavailable for a survey.

Criterion ★2.1.2

Patients are interviewed and examined in surroundings designed to ensure privacy. Discussion or consultation involving patients is conducted discreetly. Individuals not directly involved in patient care are not present without the consent of the patient concerned.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 2.1A). Agreement between joint and self assessment was 74%, and between principal and second surveyor 81% (Table 2.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method

Assessment of criterion:

The criterion was regarded as reflecting good general practice by all practices and surveyors (Table 2.1G). The criterion was acceptable to 99% of practices and 100% of surveyors (Table 2.1H) and was seen as achievable by 99% of surveyors and 98% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★2.1.2 - Indicators:

☐ ***A. The doctor(s) and staff can describe how they ensure patient confidentiality*** **(doctor interview, staff interview).**

☐ ***B. Visual and auditory privacy is ensured in the consultation room(s)*** **(direct observation).**

☐ ***C. There is a private area, eg a screen or curtain, for patients to undress*** **(direct observation).**

☐ ***D. The practice attempts to ensure auditory privacy in the waiting room, for example by using background music to mask conversations*** **(direct observation).**

☐ ***E. The waiting room is separate from the reception area*** **(direct observation).**

☐ ***F. Other (specify) .....***

Comments on Indicators by Surveyors:

Indicator E was criticised for being poorly worded as it implies that waiting room and reception must be separate. It was pointed out that this is structurally impossible in many practices and probably medically dangerous as patients cannot be observed. Many surveyors recommended that this indicator be deleted.

There was an observation that some doctors regard screens (indicator C) as superfluous, and leave the room or turn away while the patient undresses. It was suggested that the wording be looked at to accommodate this type of situation. It was also noted that it would be of value to find out what level of privacy patients felt they required during dressing and undressing.

It was agreed that patient survey data would be useful if an appropriate question was asked.

Criterion★2.1.3

All communications and records pertaining to patients are treated as confidential.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion for each assessment method (Table 2.1A). Agreement between joint and self assessment was 81%, and between principal and second surveyor 90% (Table 2.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

.Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 2.1G). This criterion was acceptable to 99% of practices and 100% of surveyors (Table 2.1H) and was seen as achievable by 98% of surveyors and 100% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★2.1.3 - Indicators:

☐ ***A. The doctor(s) and staff can describe how they ensure confidentiality of medical records and other documents pertaining to patients*** **(doctor interview, staff interview).**

☐ ***B. There is an appropriate method of disposal of material containing patient identifying information*** **(doctor interview, staff interview).**

☐ ***C. Staff are aware of confidentiality requirements for all patient encounters and recognise significant breaches of confidentiality as a 'dismissible offence'*** **(staff interview).**

☐ ***D. Medical records, and other files containing patient information, are not stored or left in areas where members of the public have unrestricted access*** **(staff interview, direct observation).**

☐ ***E. Other (specify) .....***

Comments on Indicators by Surveyors:

No comments were made on these indicators at any of the surveyor workshops.

Criterion★2.1.4

The practice acknowledges the right of patients to refuse any treatment, advice or procedure. Refusal may not absolve the treating doctor of the duty of ensuring the patients continuing care through appropriate referral to other providers.

Results for this criterion in the Field Test:

Practice compliance:

All practices met this criterion by each assessment method (Table 2.1A). Agreement between joint and self assessment was 96%, and between principal and second surveyor 98% (Table 2.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by all practices and surveyors (Table 2.1G). The criterion was acceptable to 98% of practices and 95% of surveyors (Table 2.1H) and was seen as achievable by 97% of surveyors and 99% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★2.1.4 - Indicators:

☐ ***A. The doctor(s) can describe how they manage a patient who refuses specific treatments* (doctor interview).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

No comments were made on these indicators at any of the surveyor workshops.

Criterion★2.1.5

The practice acknowledges and, if requested, facilitates the right of patients to seek a further opinion.

Results for this criterion in the Field Test:

Practice compliance:

All practices met this criterion by each assessment method (Table 2.1A). Agreement between joint and self assessment was 98%, and between principal and second surveyor 100% (Table 2.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 98% of practices and surveyors (Table 2.1G). The criterion was acceptable to 95% of practices and 95% of surveyors (Table 2.1H) and was seen as achievable by 91% of surveyors and 99% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★2.1.5 - Indicators:

☐ ***A. The doctor(s) can describe how they manage a patient who intends to seek a further opinion* (doctor interview).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

No comments were made on these indicators at any of the surveyor workshops.

Criterion★2.1.6

The practice acknowledges the right of patients to transfer their care to another doctor in the same practice or in another practice. Similarly, the treating doctor has the right to discontinue treatment of a patient. A doctor making such a decision assists the patient to find an alternative doctor.

Results for this criterion in the Field Test:

Practice compliance:

All practices met this criterion by each assessment method (Table 2.1A). Agreement between joint and self assessment was 90%, and between principal and second surveyor 98% (Table 2.1B). Excluding the 'not applicable' data, practices were more likely to have achieved a 'substantial' level through joint assessment (99%) compared to self assessment (92%) (χ^2=13.39,df=1,p<0.01) (Tables 2.1E&F). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 2.1G) and was acceptable to 96% of practices and 97% of surveyors (Table 2.1H). Solo practices were less likely to agree that the criterion is acceptable in a set of minimum standards. Excluding the 'don't know' group 8% of solo practices considered this unacceptable compared to 1% of other practices (χ^2=4.96,df=1,p=0.03) (data not shown). The criterion was seen as achievable by 100% of surveyors and 99% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★2.1.6 - Indicators:

☐ ***A. The doctor(s) can describe how they manage a patient who wants to leave the practice* (doctor interview).**

☐ ***B. The doctor(s) can describe how they manage a patient who they no longer wish to treat* (doctor interview).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

No comments were made on these indicators at any of the surveyor workshops.

Criterion★2.1.7

Participation by patients in clinical training programs involving observation of the consultation or involvement by a third party occurs only with the explicit consent of the patient after receiving information about the programs.

Results for this criterion in the Field Test:

Practice compliance:

Over 97% of practices met this criterion for each assessment method, although for a large number of practices it was rated as 'not applicable' (Table 2.1A). Agreement between joint and self assessment was 54%, and between principal and second surveyor 77% (Table 2.1B). There was a significant difference between surveyor assessment and practice self assessment, 53% of joint assessments considering this criterion to be 'not applicable' compared to 28% of self assessments (χ^2=26.75,df=1,p<0.01) (data not shown). Practices in RARA 1/2 (63%) were more likely to receive a rating of 'not applicable' for joint assessment than practices in other areas (42%) (χ^2=7.45,df=1,p<0.01)(data not shown). There was a significant relationship between both practice size and both joint (χ^2=18.86,df=6,p<0.01) and self (χ^2=28.95,df=6,p<0.01) assessment. Solo practices were more likely to receive a rating of 'not applicable' (data not shown), and larger practices were more likely to 'substantially' meet the criterion (Tables 2.1E&F). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method

(Tables 2.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 93% of practices and 100% of surveyors (Table 2.1G). The criterion was acceptable to 90% of practices and 91% of surveyors (Table 2.1H) and was seen as achievable by 93% of surveyors and 89% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ✭2.1.7 - Indicators:

☐ ***A. The doctor(s) can describe how they obtain patient consent for involvement in clinical training programs*** **(doctor interview)*.***

☐ ***B. Where appropriate, there is evidence of patient consent for participation in clinical training programs noted in the medical records*** **(medical records review)*.***

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

All surveyors agreed that this was essential criterion for practices involved in training programs. There was some confusion as to whether the criterion requires participation in training programs (which it does not) or simply that patient consent is obtained when the programs are occurring (which is the intent).

The point was made by the Vic group that only 'good' practices are involved in clinical training programs and therefore the important part of this criteria should not be whether the practices undertake clinical training or not, but whether patient consent is obtained.

It was felt that the relatively low inter-rater reliability for this criterion was due to the fact that surveyors had different interpretations of the nature of "consent". Many surveyors were unsure of what constituted appropriate consent and suggested that the criterion (or at least the indicators) should make this clear.

The RACGP definition of consent needs to be clear, and surveyors need to be aware of it. Patients must be asked outside of the consultation itself about whether they mind having a third person sitting in on the consultation either by the receptionist or even on the telephone when booking the appointment.

The WA, SA and Qld surveyors suggested that indicator B (consent noted in medical records) should be dropped or amended to reflect the fact that patient consent should be obtained at the time the appointment is made, or at least on arrival at the surgery if the former is not possible. There was doubt about the value of including a record of consent in the patient records as this implies that consent has been obtained only when the patient is in the consultation room.

The surveyors suggested some additional indicators:

Staff can describe how and when patients are informed of the presence of a third party in consultations.

The practice displays a sign in the waiting room informing patients that the practice is involved in clinical training programs. Information is included about when this will be occurring and which doctor(s) will be affected.

It was agreed that a patient survey indicator could (and should) also be added but difficulties were perceived with both framing an appropriate question and finding enough patients who had experience of the training programs.

From the point of view of practice visits, it was felt that information on whether practices are involved in training programs should be obtained prior to the visit in order to save surveyors asking irrelevant questions.

Criterion★2.1.8

Participation by patients in the gathering of data for research projects which involve the identification of patients, occurs only with the explicit and written consent of the patient after receiving a written and oral explanation about the proposed research. Patients have the right to withdraw their consent. Research projects in general practice should be approved by an appropriate ethics committee.

Results for this criterion in the Field Test:

Practice compliance:

Over 93% of practices met this criterion for each assessment method, although there were large numbers of practices who received a rating of 'not applicable'. However, by self assessment 6% of practices failed to meet this criterion compared to 1% by joint assessment (χ^2=11.35,df=1,p<0.01) (Table 2.1A). Agreement between joint and self assessment was 62%, and between principal and second surveyor 88% (Table 2.1B). This criterion was considered 'not applicable' 86% of the time by joint assessment compared to 59% by self assessment (χ^2=36.09,df=1,p<0.01) (data not shown). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 93% of practices and 97% of surveyors (Table 2.1G). The criterion was acceptable to 87% of practices and 90% of surveyors (Table 2.1H) and was seen as achievable by 91% of surveyors and 84% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★2.1.8 - Indicators:

☐ ***A. The doctor(s) can describe how they obtain patient consent for involvement in research projects*** **(doctor interview)*.***

☐ ***B. Where appropriate, there is evidence of consent to participation in research projects noted in the medical records*** **(medical records review)*.***

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

Surveyors made the observation that this was usually not applicable in the practices visited, "so was a bloody nuisance to have to assess every time." There was agreement that this criterion should be amalgamated with 2.1.7 which deals with similar issues.

There was some misunderstanding about the intention of the criterion, the Qld surveyors asking that the wording be "made clearer". No suggestions were made as to what was needed.

Criterion★2.1.9

The practice acknowledges and responds to patient complaints.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion for each assessment method (Table 2.1A). Agreement between joint and self assessment was 79%, and between principal and second surveyor 95% (Table 2.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 2.1G). The criterion was acceptable to 90% of practices and 91% of surveyors (Table 2.1H)

and was seen as achievable by 86% of surveyors and 98% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★2.1.9 - Indicators:

☐ ***A. The doctor(s) and staff can describe the practice procedures for dealing with complaints from patients and others*** **(doctor interview, staff interview).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

No comments were made on these indicators at any of the surveyor workshops.

Criterion ★2.1.10

The practice maintains confidentiality and privacy of patients' accounts. Where patients' accounts are released to a third party, the information contained is not of a clinical nature.

Results for this criterion in the Field Test:

Practice compliance:

All practices met this criterion by each assessment method (Table 2.1A). Agreement between joint and self assessment was 88%, and between principal and second surveyor 92% (Table 2.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 2.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 98% of practices and surveyors (Table 2.1G). The criterion was acceptable to 97% of practices and 95% of surveyors (Table 2.1H) and was seen as achievable by 93% of surveyors and 99% of practices (Table 2.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★2.1.10 - Indicators:

☐ ***A. Staff can describe how they ensure confidentiality of patient accounts*** **(staff interview).**

☐ ***B. Patient accounts and related correspondence do not contain clinical information*** **(documents and other records).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

No comments were made on these indicators at any of the workshops.

Table 2.1A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
2.1 Rights and needs of patients				
*2.1.1 respectful care	100	100	100	100
*2.1.2 right to privacy	100	100	100	100
*2.1.3 record confidentiality	99	100	99	99
*2.1.4 right to refuse treatment	100	100	100	100
*2.1.5 right to further opinion	100	100	100	100
*2.1.6 right to transfer from practice	100	100	100	100
*2.1.7 consent: clinical training	99	97	98	99
*2.1.8 consent: research programs	**100**	**94**[1]	99	100
*2.1.9 acknowledges complaints	100	99	99	99
*2.1.10 privacy of accounts	100	100	100	100

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria. By self assessment more practices failed to meet

this criterion compared to joint assessment (χ^2=11.35,df=1,p<0.01).

Table 2.1B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
2.1 Rights and needs of patients		
*2.1.1 respectful care	100	99
*2.1.2 right to privacy	74	81
*2.1.3 record confidentiality	81	90
*2.1.4 right to refuse treatment	96	98
*2.1.5 right to further opinion	98	100
*2.1.6 right to transfer from practice	90	98
*2.1.7 consent: clinical training	54	77
*2.1.8 consent: research programs	62	88
*2.1.9 acknowledges complaints	79	95
*2.1.10 privacy of accounts	88	92

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 2.1C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
2.1 Rights and needs of patients	**97**	**96**	**98**	**98**	**94**	**97**	**99**
*2.1.1 respectful care	100	100	100	100	100	100	100
*2.1.2 right to privacy	100	100	100	100	100	100	100
*2.1.3 record confidentiality	99	98	100	100	96	100	100
*2.1.4 right to refuse treatment	100	100	100	100	100	100	100
*2.1.5 right to further opinion	100	100	100	100	100	100	100
*2.1.6 right to transfer from practice	100	100	100	100	100	100	100
*2.1.7 consent: clinical training	99	99	98	100	98	98	100
*2.1.8 consent: research programs	100	99	100	100	98	100	100
*2.1.9 acknowledges complaints	100	100	100	98	100	98	100
*2.1.10 privacy of accounts	100	100	100	100	100	100	100

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 2.1D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
2.1 Rights and needs of patients	**91**	**95**	**88**	**86**	**86**	**94**	**92**
*2.1.1 respectful care	100	100	100	100	100	100	100
*2.1.2 right to privacy	100	100	100	100	100	100	100
*2.1.3 record confidentiality	100	100	100	100	100	100	100
*2.1.4 right to refuse treatment	100	100	100	100	100	100	100
*2.1.5 right to further opinion	100	100	100	100	100	100	100
*2.1.6 right to transfer from practice	100	100	100	100	100	100	100
*2.1.7 consent: clinical training	97	98	98	96	92	100	99
*2.1.8 consent: research programs	94	96	94	90	92	98	92
*2.1.9 acknowledges complaints	99	100	96	98	100	95	100
*2.1.10 privacy of accounts	100	100	100	100	100	100	100

Table 2.1E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
2.1 Rights and needs of patients							
*2.1.1 respectful care	100	99	100	100	100	100	99
*2.1.2 right to privacy	80	76	82	85	80	78	81
*2.1.3 record confidentiality	86	85	86	88	82	88	87
*2.1.4 right to refuse treatment	97	98	98	96	96	97	99
*2.1.5 right to further opinion	100	100	100	100	100	100	100
*2.1.6 right to transfer from practice	**99**[1]	98	100	98	98	98	99
*2.1.7 consent: clinical training	**40**[2]	**34**[3]	**48**	**44**	**18**[4]	**42**	**51**
*2.1.8 consent: research programs	**11**[5]	15	8	6	4	14	13
*2.1.9 acknowledges complaints	94	94	92	96	92	92	96
*2.1.10 privacy of accounts	91	90	90	94	90	84	96

[1] Practices were more likely to have achieved a 'substantial' level for this criterion through joint assessment compared to self assessment (χ^2=13.39,df=1,p<0.01). [2] There was a significant difference between surveyor assessment and practice self assessment on the level of performance on this criterion. Surveyors more frequently considered this criterion to be 'not applicable' compared to self assessments (χ^2=26.75,df=1,p<0.01). [3] Practices in RARA 1/2 were more likely to receive a rating of 'not applicable' and therefore less likely to be rated 'substantial' than practices in other areas (χ^2=7.45,df=1,p<0.01). [4] There was also a significant relationship for size of practice and performance in this criterion (χ^2=18.86,df=6,p<0.01). [5]This criterion was considered 'not applicable' 86% of the time by joint assessment compared to 59% by self assessment (χ^2=36.09,df=1,p<0.01).

Table 2.1F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
2.1 Rights and needs of patients							
*2.1.1 respectful care	100	99	100	100	100	100	99
*2.1.2 right to privacy	83	84	83	80	82	79	86
*2.1.3 record confidentiality	92	90	96	94	94	91	93
*2.1.4 right to refuse treatment	97	97	96	98	100	95	96
*2.1.5 right to further opinion	99	100	98	96	96	98	100
*2.1.6 right to transfer from practice	**91**[1]	93	84	94	86	92	93
*2.1.7 consent: clinical training	**56**[2]	53	62	57	**38**[3]	**56**	**68**
*2.1.8 consent: research programs	**26**[4]	31	20	22	21	28	28
*2.1.9 acknowledges complaints	82	84	76	84	76	80	87
*2.1.10 privacy of accounts	92	91	96	90	92	88	95

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Practices were more likely to have achieved a 'substantial' level for this criterion through joint assessment compared to self assessment (χ^2=13.39,df=1,p<0.01). [2]There was a significant difference between surveyor assessment and practice self assessment on the level of performance on this criterion. Surveyors more frequently considered this criterion to be 'not applicable' compared to self assessments (χ^2=26.75,df=1,p<0.01). [3]There was a significant relationship for size of practice and performance on self assessment (χ^2=28.95,df=6,p<0.01). [4]This criterion was considered 'not applicable' 86% of the time by joint assessment compared to 59% by self assessment (χ^2=36.09,df=1,p<0.01).

Table 2.1G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
2.1 Rights and needs of patients								
*2.1.1 respectful care	100	100	100	100	100	100	100	100
*2.1.2 right to privacy	100	100	100	100	100	100	100	100
*2.1.3 record confidentiality	100	99	100	98	100	100	100	99
*2.1.4 right to refuse treatment	100	100	100	100	100	100	100	100
*2.1.5 right to further opinion	98	99	99	98	100	100	96	100
*2.1.6 right to transfer from practice	100	99	100	98	100	98	100	100
*2.1.7 consent: clinical training	100	93	94	89	95	88	91	97
*2.1.8 consent: research programs	97	93	94	95	89	90	94	93
*2.1.9 acknowledges complaints	100	99	100	98	100	100	98	100
*2.1.10 privacy of accounts	98	99	99	98	100	98	98	100

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 2.1H Response to : "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
2.1 Rights and needs of patients								
*2.1.1 respectful care	97	98	99	98	95	**90**[1]	**100**	**100**
*2.1.2 right to privacy	100	99	100	98	100	98	100	100
*2.1.3 record confidentiality	100	99	100	96	100	98	100	99
*2.1.4 right to refuse treatment	95	98	99	98	95	92	100	99
*2.1.5 right to further opinion	95	95	95	91	98	93	94	96
*2.1.6 right to transfer from practice	97	96	96	96	98	**88**[2]	**100**	**99**
*2.1.7 consent: clinical training	91	90	91	86	93	84	92	92
*2.1.8 consent: research programs	90	87	90	84	85	82	92	86
*2.1.9 acknowledges complaints	91	90	92	88	90	85	91	93
*2.1.10 privacy of accounts	95	97	98	95	97	95	98	97

[1] More solo practices considered this criterion to be unacceptable compared to other practices (χ^2=8.84,df=1,p<0.01). [2] Solo practices were less likely to agree that this criterion is acceptable in a set of minimum standards (χ^2=4.96,df=1,p=0.03).

Table 2.1I Response to : "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
2.1 Rights and needs of patients								
*2.1.1 respectful care	97	99	99	100	100	98	100	100
*2.1.2 right to privacy	98	99	99	100	100	98	100	100
*2.1.3 record confidentiality	98	100	100	100	100	100	100	100
*2.1.4 right to refuse treatment	97	99	99	100	100	97	100	100
*2.1.5 right to further opinion	91	99	100	98	100	100	98	100
*2.1.6 right to transfer from practice	100	99	99	100	100	100	98	100
*2.1.7 consent: clinical training	93	89	92	86	88	81	92	92
*2.1.8 consent: research programs	91	84	90	81	75	87	88	78
*2.1.9 acknowledges complaints	86	98	99	98	98	98	96	100
*2.1.10 privacy of accounts	93	99	98	100	100	98	98	100

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Section Three: QUALITY ASSURANCE AND EDUCATION

Standard 3.1 Quality assurance and continuing education

The practice is committed to the principles of quality assurance and continuing education.

Brief explanation: ***Quality assurance consists of educational and practice based activities which maintain a high professional standard. It also involves a commitment to acquiring new knowledge and skills by a process of continuing education and training.***

Criterion★3.1.1

All medical staff participate in quality assurance and continuing medical education.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 3.1A). Agreement between joint and self assessment was 89%, and between principal and second surveyor 97% (Table 3.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 3.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 95% of practices and surveyors (Table 3.1G) and was acceptable to 90% of both practices and surveyors (Table 3.1H). Although there was an association evident between practice size and response to acceptability of this criterion, (Table 3.1H) this was due to the high proportion of solo GPs who answered 'don't know'. There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★3.1.1 Indicators:

☐ ***A. The practice is able to demonstrate that all GPs are involved in quality assurance and continuing education*** **(doctor interview).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion 3.1.2

All staff involved in patient care demonstrate a commitment to continuing education and to the maintenance of appropriate standards of care.

Results for this criterion in the Field Test:

Practice compliance:

Over 84% of practices met this criterion for each assessment method (Table 3.1A). Practices that met this criterion were more likely through joint assessment (57%) than self assessment (40%) to be judged to have 'substantially' met the criterion (χ^2=9.33,df=1,p<0.01) (data not shown). Agreement between joint and self assessment was 51%, and between principal and second surveyor 72% (Table 3.1B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 3.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 96% of practices and surveyors (Table 3.1G). The criterion was acceptable to 86% of practices and 93% of surveyors (Table 3.1H) and was seen as achievable by 72% of surveyors and 91% of practices (Table 3.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or

the size of practice.

Criterion 3.1.2 Indicators:

☐ ***A.[6] Staff have completed a St John's ambulance first aid course or equivalent*** **(doctor interview, staff interview, documents and other records).**

☐ ***B. Appropriate practice staff have participated in medical receptionist training, for example an RACGP course, an Australian Association of Practice Managers course or local TAFE course*** **(doctor interview, staff interview, documents and other records).**

☐ ***C. Appropriate practice staff have completed a medical terminology course*** **(doctor interview, staff interview, documents and other records).**

☐ ***D. Practice nursing staff have appropriate nursing training and experience and participate in appropriate continuing education*** **(doctor interview, staff interview, documents and other records).**

☐ ***E. The practice provides in-house training for staff*** **(doctor interview, staff interview, documents and other records).**

☐ ***F. Other (specify) .....***

Comments on Indicators by Surveyors:

There was some confusion among surveyors as to what this criterion required. Many felt it was unfair "to require a perfectly good receptionist with many years experience to have completed all these courses".

It was felt that the criterion and indicators should recognise that experience was perhaps as valuable as formal training.

Criterion ★ 3.1.3

The doctor(s) and staff regularly review the administration of the practice.

Results for this criterion in the Field Test:

Practice compliance:

Over 97% of practices met this criterion for each assessment method (Table 3.1A). For those practices that met this criterion through joint assessment, less medium sized practices (64%) than other practices (83%) were judged 'substantial' (χ^2=8.40,df=1,p<0.01) (data not shown). Agreement between joint and self assessment was 71%, and between principal and second surveyor 85% (Table 3.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 3.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 93% of practices and surveyors (Table 3.1G). The criterion was acceptable to 81% of practices and 83% of surveyors (Table 3.1H) and was seen as achievable by 70% of surveyors and 91% of practices (Table 3.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 3.1.3 Indicators:

☐ ***A. Staff are able to discuss administrative matters with the doctor(s) when necessary*** **(doctor interview, staff interview).**

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[6] It is recognised that the indicators for 3.1.2 are desirable rather than essential.

☐ ***B. There is a regular staff meeting*** **(doctor interview, staff interview).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Table 3.1A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
3.1 Quality assurance & continuing education				
*3.1.1 medical staff	99	100	99	100
3.1.2 staff involved in patient care	88	88	85	89
*3.1.3 administrative review	98	99	97	98

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 3.1B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
3.1 Quality assurance & continuing education		
*3.1.1 medical staff	89	97
3.1.2 staff involved in patient care	51	72
*3.1.3 administrative review	71	85

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 3.1C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
3.1 Quality assurance & continuing education	**98**	**97**	**96**	**100**	**96**	**98**	**98**
*3.1.1 medical staff	99	99	98	100	98	98	100
3.1.2 staff involved in patient care	88	86	88	92	82	83	95
*3.1.3 administrative review	98	98	96	100	98	98	98

Table 3.1D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
3.1 Quality assurance & continuing education	**99**	**99**	**100**	**96**	**98**	**98**	**99**
*3.1.1 medical staff	100	100	100	98	98	100	100
3.1.2 staff involved in patient care	88	86	92	90	90	84	90
*3.1.3 administrative review	99	99	100	98	100	98	99

Table 3.1E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
3.1 Quality assurance & continuing education							
*3.1.1 medical staff	93	94	92	94	90	95	94
3.1.2 staff involved in patient care	**49**[1]	48	50	51	44	46	54
*3.1.3 administrative review	74	77	66	77	**80**	**63**[2]	**80**

[1] Practices that met this criterion were more likely through joint than self assessment to have 'substantially' met the criterion (χ^2=9.33,df=1,p<0.01). [2] Medium sized practices were less likely to have been judged 'substantial' compared to other practices (χ^2=8.40,df=1,p<0.01).

Table 3.1F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
3.1 Quality assurance & continuing education							

Standard / Criterion	All	R1	R3	R4	So	2+	4+
*3.1.1 medical staff	96	95	98	96	96	95	96
3.1.2 staff involved in patient care	35[1]	33	44	29	13	31	40
*3.1.3 administrative review	65	62	70	65	57	66	69

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Practices that met this criterion were more likely through joint than self assessment to have 'substantially' met the criterion (χ^2=9.33,df=1,p<0.01).

Table 3.1G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
3.1 Quality assurance & continuing education								
*3.1.1 medical staff	100	95	95	94	95	91	96	96
3.1.2 staff involved in patient care	100	96	95	96	100	93	98	97
*3.1.3 administrative review	98	94	95	91	93	86	93	99

Table 3.1H Response to : "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
3.1 Quality assurance & continuing education								
*3.1.1 medical staff	90	90	87	96	90	82	94	92
3.1.2 staff involved in patient care	86	93	91	93	95	87	96	93
*3.1.3 administrative review	83	81	83	77	83	73	83	85

Table 3.1I Response to : "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
3.1 Quality assurance & continuing education								
*3.1.1 medical staff	81	95	95	93	98	90	98	96
3.1.2 staff involved in patient care	72	91	88	95	93	85	90	96
*3.1.3 administrative review	70	91	90	89	93	83	89	96

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Section Four: PRACTICE ADMINISTRATION

Standard 4.1 Practice staff

Practice staff deal with patients in a helpful and competent way and are able to identify emergencies and deal with complaints.

Brief explanation: ***Receptionists, practice nurses and practice managers should share the practice's commitment to providing quality care for patients.***[7]

Criterion★4.1.1

At least one person is present in the practice during normal practice hours who can provide practical help in an emergency.

Results for this criterion in the Field Test:

Practice compliance:

Over 96% of practices met this criterion for each assessment method (Table 4.1A). By self assessment 6% of solo practices rated this criterion as 'not applicable' while no other practices rated it 'not applicable' (χ^2=8.36,df=1,p<0.01). Agreement between joint and self assessment was 90%, and between principal and second surveyor 93% (Table 4.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 4.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 96% of practices and surveyors (Table 4.1G). The criterion was acceptable to 87% of practices and 93% of surveyors (Table 4.1H) and was seen as achievable by 90% of surveyors and 97% of practices (Table 4.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★4.1.1 Indicators:

☐ ***A. When the practice is open a person is available who can, for example, dial for an ambulance, assist in lifting an unconscious person etc*** **(doctor interview, staff interview).**

☐ ***B. At least one staff member is present when the practice is open*** **(doctor interview, staff interview).**

☐ ***C. Other (specify) .....***

Note:	This need not apply to the small branches of those rural practices that have offices in a number of locations.

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion★4.1.2

Staff have appropriate inter-personal skills for working in a medical practice.

Results for this criterion in the Field Test:

Practice compliance:

[7] See, for example, Arber, S. and Sawyer, L. The role of the receptionist in general practice: a 'dragon behind the desk'? Soc. Sci. Med. 1985:20(9); 911-921.

Almost all practices met this criterion by each assessment method (Table 4.1A). By self assessment, solo practices (2%) were more likely to regard this criterion as 'not applicable' than were other practices (nil) (χ^2=8.45,df=1,p=0.01) (data not shown). Agreement between joint and self assessment was 95%, and between principal and second surveyor 97% (Table 4.1B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 4.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 98% of practices and by all surveyors (Table 4.1G). The criterion was acceptable to 91% of practices and 92% of surveyors (Table 4.1H) and was seen as achievable by 97% of practices and 90% of surveyors (Table 4.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★4.1.2 Indicators:

☐ ***A. Staff demonstrate adequate communication skills in direct communication or on the telephone*** **(direct observation)*.***

☐ ***B. Patients are satisfied with the general attitude of staff*** **(patient survey)*.***

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Table 4.1A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
4.1 Practice staff				
*4.1.1 person for practical help	97	100	96	98
*4.1.2 inter-personal skills	100	100	99	100

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 4.1B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
4.1 Practice staff		
*4.1.1 person for practical help	90	93
*4.1.2 inter-personal skills	95	97

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 4.1C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.1 Practice staff	**97**	**96**	**98**	**98**	**92**	**100**	**98**
*4.1.1 person for practical help	97	96	98	98	92	100	98
*4.1.2 inter-personal skills	100	99	100	100	98	100	100

Table 4.1D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.1 Practice staff	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*4.1.1 person for practical help	100	100	100	100	100	100	100
*4.1.2 inter-personal skills	100	100	100	100	100	100	100

Table 4.1E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.1 Practice staff							
*4.1.1 person for practical help	92	90	94	96	88	97	92
*4.1.2 inter-personal skills	97	97	96	98	94	98	98

Table 4.1F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.1 Practice staff							
*4.1.1 person for practical help	95	93	96	98	92	91	100
*4.1.2 inter-personal skills	96	95	98	96	90	97	99

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 4.1G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.1 Practice staff								
*4.1.1 person for practical help	97	98	99	94	100	93	100	99
*4.1.2 inter-personal skills	100	98	99	98	98	95	98	100

Table 4.1H Response to : "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.1 Practice staff								
*4.1.1 person for practical help	93	87	88	86	88	88	93	83
*4.1.2 inter-personal skills	91	92	94	91	90	90	93	93

Table 4.1I Response to : "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.1 Practice staff								
*4.1.1 person for practical help	90	97	95	98	98	90	98	99
*4.1.2 inter-personal skills	90	97	96	98	98	93	100	97

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Standard 4.2 Medical records system

Medical records are easily accessible within the practice for individual patient care, health promotion, audit and research, paying due regard to confidentiality and patient rights.

<u>Brief explanation:</u> A well organised system of medical records[8] will contribute to the smooth running of the practice and quality care.

The system of records used is an administrative concern and so is included under Practice Administration. The content of medical records is a clinical concern and is therefore included under Practice Services.

Criterion ★4.2.1

The records are comprehensive, well organised, legible and accurate.

Results for this criterion in the Field Test:

<u>Practice compliance:</u>

Over 94% of practices met this criterion by each assessment method. By joint assessment, 5% of practices failed to meet this criterion compared to 1% by self assessment (χ^2=8.76,df=1,p<0.01)

[8] The RACGP Health Record is an example of a problem oriented, flexible structured record.

(Table 4.2A). Agreement between joint and self assessment was 74%, and between principal and second surveyor 88% (Table 4.2B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 4.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by all practices and by 97% of surveyors (Table 4.2G). The criterion was acceptable to 95% of practices and 91% of surveyors (Table 4.2H) and was seen as achievable by 88% of practices and 62% of surveyors (Table 4.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★4.2.1 Indicators:

☐ ***A. For each regular patient there is an individual file containing all clinical information relating to that patient. This file includes the patients' medical record, letters received from consultants and hospitals and all pathology and X-ray reports*** **(medical records review).**

☐ ***B. There is a separate medical record for each patient, which may or may not be contained in a family medical folder*** **(medical records review).**

☐ ***C. Individual patient records can be easily accessed within the practice*** **(direct observation).**

☐ ***D. Procedures exist for incorporation of responses to referrals to be included in the patient's individual file*** **(doctor interview, staff interview, medical records review).**

☐ ***E. Other (specify) .....***

Comments on Indicators by Surveyors:

The NSW group suggested indicator A should be changed to read "For each regular patient there is an individual record " rather than an individual file.

It was noted by some of the surveyors in the WA group that this criterion was a poor discriminator between good and bad practices.

It was pointed out by some surveyors however that it should not be important that every criterion is a good discriminator (some criteria have educational value) but that the standards document as a whole is a good discriminator.

Criterion ★4.2.2

Confidentiality, privacy and security of records are maintained.

Results for this criterion in the Field Test:

Practice compliance:

Between 98% and 100% of practices met this criterion for each assessment method (Table 4.2A). Six percent of solo practices failed to meet this criterion by joint assessment compared to 1% of other practices (χ^2=5.14,df=1,p=0.04) (Table 4.2C). Agreement between joint and self assessment was 87%, and between principal and second surveyor 91% (Table 4.2B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 4.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by all practices and surveyors (Table 4.2G). The criterion was acceptable to 99% of practices and 100% of surveyors (Table 4.2H) and was seen as achievable by 95% of surveyors and 99% of practices (Table 4.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★4.2.2 Indicators:

☐ ***A. Medical records are not stored or left in areas where members of the public have unrestricted access* (direct observation, staff interview).**

☐ ***B. The doctor(s) and staff can describe how they ensure confidentiality of medical records* (doctor interview, staff interview).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion ★4.2.3

On request by the patient, the practice transfers a copy of a patients' medical record, or a summary, to another medical practitioner.

Results for this criterion in the Field Test:

Practice compliance:

Virtually all practices met this criterion by each assessment method (Table 4.2A). Agreement between joint and self assessment was 95%, and between principal and second surveyor 99% (Table 4.2B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 4.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 98% of practices and surveyors (Table 4.2G). The criterion was acceptable to 95% of practices and 97% of surveyors (Table 4.2H) and was seen as achievable by 95% of surveyors and 98% of practices (Table 4.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★4.2.3 Indicators:

☐ ***A. The doctor(s) and staff can describe the procedures for transferring records to another practice* (doctor interview, staff interview).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

The NSW group suggested adding an indicator stating that "a note of request to transfer records is kept on file."

Criterion ★4.2.4

There is a system for follow up and recall of patients with significantly abnormal test results.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion for each assessment method (Table 4.2A). Agreement between joint and self assessment was 84%, and between principal and second surveyor 88% (Table 4.2B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 4.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 99% of practices and 100% of surveyors (Table 4.2G). The criterion was acceptable to 98% of practices and 95% of surveyors (Table 4.2H) and was seen as achievable by 81% of surveyors and 96% of practices (Table 4.2I).

There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★4.2.4 Indicators:

☐ ***A. The doctor(s) can describe the procedure for follow up and recall of patients with significantly abnormal test results*** **(doctor interview).**

☐ ***B. There is a system for taking appropriate action on test results, eg the doctor initials each result and indicates appropriate action*** **(doctor interview, staff interview).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

The potentially disastrous scenario of an abnormal test result being lost or misplaced when the doctor is away or on holiday was discussed by one surveyor group. It was agreed that an indicator should be added to deal with this type of situation - this could suggest that a stamp be placed on every test result to show that a doctor has seen it.

Table 4.2A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
4.2 Medical records system				
*4.2.1 comprehensive, well organised	**95**[1]	**100**	95	95
*4.2.2 confidentiality	98	100	98	99
*4.2.3 transfer on request	100	100	100	100
*4.2.4 follow up abnormal results	99	100	99	99

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria. [1] By joint assessment, significantly more practices failed to meet this criterion compared to self assessment (χ^2=8.76,df=1,p<0.01).

Table 4.2B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
4.2 Medical records system		
*4.2.1 comprehensive, well organised	74	88
*4.2.2 confidentiality	87	91
*4.2.3 transfer on request	95	99
*4.2.4 follow up abnormal results	84	88

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 4.2C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.2 Medical records system	**92**	**94**	**88**	**94**	**90**	**91**	**95**
*4.2.1 comprehensive, well organised	95	96	90	98	96	94	95
*4.2.2 confidentiality	98	98	98	98	**94**[1]	**98**	**100**
*4.2.3 transfer on request	100	100	100	98	100	98	100
*4.2.4 follow up abnormal results	99	100	98	98	94	100	100

[1] Significantly more solo practices failed to meet this criterion compared to other practices (χ^2=5.14,df=1,p=0.04).

Table 4.2D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.2 Medical records system	**99**	**98**	**100**	**98**	**94**	**100**	**100**
*4.2.1 comprehensive, well organised	**100**	100	100	98	98	100	100
*4.2.2 confidentiality	100	100	100	100	100	100	100
*4.2.3 transfer on request	100	99	100	100	98	100	100
*4.2.4 follow up abnormal results	100	99	100	100	98	100	100

Table 4.2E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.2 Medical records system							
*4.2.1 comprehensive, well organised	78	77	72	85	74	78	80
*4.2.2 confidentiality	88	86	92	90	88	94	84
*4.2.3 transfer on request	98	97	100	96	96	95	100
*4.2.4 follow up abnormal results	88	92	84	85	90	89	87

Table 4.2F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.2 Medical records system							
*4.2.1 comprehensive, well organised	87	86	88	89	92	84	87
*4.2.2 confidentiality	96	96	98	96	94	97	98
*4.2.3 transfer on request	98	98	96	98	94	100	98
*4.2.4 follow up abnormal results	92	92	94	92	92	95	90

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 4.2G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.2 Medical records system								
*4.2.1 comprehensive, well organised	97	100	100	100	100	100	100	100
*4.2.2 confidentiality	100	100	100	100	100	100	100	100
*4.2.3 transfer on request	98	98	100	96	98	98	98	99
*4.2.4 follow up abnormal results	100	99	99	100	100	98	100	100

Table 4.2H Response to : "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.2 Medical records system								
*4.2.1 comprehensive, well organised	91	95	99	89	95	95	98	93
*4.2.2 confidentiality	100	99	99	98	100	98	98	100
*4.2.3 transfer on request	97	95	94	93	100	90	94	99
*4.2.4 follow up abnormal results	95	98	98	100	98	98	98	99

Table 4.2I Response to : "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.2 Medical records system								
*4.2.1 comprehensive, well organised	62	88	89	83	90	93	89	84
*4.2.2 confidentiality	95	99	100	100	98	98	100	100
*4.2.3 transfer on request	95	98	99	98	98	98	98	99
*4.2.4 follow up abnormal results	81	96	94	100	95	95	94	97

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Standard 4.3 Control of Practice

The practice is under the clinical control of general practitioners.

Brief explanation: ***GPs principal responsibility is towards their patients and not their employers or the owners of their practice.***

Criterion★4.3.1

The practice ensures that all doctors in the practice may exercise full autonomy in decisions that effect clinical care.

Results for this criterion in the Field Test:

Practice compliance:

All practices met this criterion by each assessment method (Table 4.3A). Agreement between joint and self assessment was 94%, and between principal and second surveyor 94% (Table 4.3B). In 10% of solo practices this criterion was considered by joint assessment to be 'not applicable' while it was considered applicable in all other practices (χ^2=14.26,df=1,p=0.01) (data not shown). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 4.3A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 98% of practices and 100% of surveyors (Table 4.3G). The criterion was acceptable to 98% of practices and 100% of surveyors (Table 4.3H) and was seen as achievable by 93% of surveyors and 99% of practices (Table 4.3I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★4.3.1 Indicators:

☐ ***A. The doctors are free to determine their own appointments schedule, subject to criterion 1.2.2*** **(doctor interview).**

☐ ***B. The doctors are free to determine the consultants to whom they refer*** **(doctor interview).**

☐ ***C. The doctors are free to determine what pathology they order, and where they order it*** **(doctor interview).**

☐ ***D. The doctors are free to determine what diagnostic services they order and where they order those services*** **(doctor interview).**

☐ ***E. The doctors are free to determine how and when to schedule follow-up appointments with individual patients*** **(doctor interview).**

☐ ***F. The doctors are free to determine whether to accept new patients, subject to criterion 2.1.1*** **(doctor interview).**

☐ ***G. The doctor(s) decide(s) what equipment and supplies the practice orders*** **(doctor interview, staff interview).**

☐ ***H. The doctor(s) decide(s) whether particular bad-debts are to be pursued*** **(doctor interview, staff interview).**

☐ ***I. The practice is generally free from any financial integration of general practitioners with services to which the general practitioners may refer*** **(doctor interview).**

☐ ***J. The practice does not require patients to return for a consultation to receive negative results of routine tests, unless for substantial medical reasons*** **(doctor interview).**

☐ ***K. Other (specify) .....***

Comments on Indicators by Surveyors:

The surveyors noted that this was a difficult criterion to measure as they had to rely only on doctor and staff interviews.

The Qld group pointed out that this criterion was a problem for group practices, for example the doctors may not be free to determine their own appointments schedule if the group 'imposes' an agreed schedule on all doctors within the practice. The point was also made in SA that rural practices often have no choice about where they order, for example, diagnostic services.

Many of the problems with this criterion appeared to be based on misunderstandings - the intent of the criterion is that doctors are free to make decisions that affect clinical care, rather than having these decisions imposed upon them. If doctors choose to make joint decisions, or if there are no choices available, this does not necessarily mean that the criterion is not being met. This may need to be made clearer in the criterion or its indicators.

Indicator A for example might be amended to read "The doctors, either individually or as a group, are free to determine their appointments schedule, subject to criterion 1.2.2 (length of consultation)."

Table 4.3A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
4.3 Control of practice				
*4.3.1 clinical autonomy	100	100	100	100

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 4.3B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
4.3 Control of practice		
*4.3.1 clinical autonomy	94	94

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 4.3C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.3 Control of practice	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*4.3.1 clinical autonomy	100	100	100	100	100	100	100

Table 4.3D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.3 Control of practice	**100**	**100**	**100**	**100**	**100**	**100**	**100**
*4.3.1 clinical autonomy	100	100	100	100	100	100	100

Table 4.3E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.3 Control of practice							
*4.3.1 clinical autonomy	95	93	100	96	**88**[1]	**100**	**96**

[1]In 10% of solo practices this criterion was considered by joint assessment to be 'not applicable'. It was considered applicable in all other practices (χ^2=14.26,df=1,p=0.01).

Table 4.3F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
4.3 Control of practice							
*4.3.1 clinical autonomy	98	99	96	98	98	97	99

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 4.3G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.3 Control of practice								
*4.3.1 clinical autonomy	100	98	98	98	100	100	98	97

Table 4.3H Response to : "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.3 Control of practice								
*4.3.1 clinical autonomy	100	98	98	95	100	97	98	97

Table 4.3I Response to : "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
4.3 Control of practice								
*4.3.1 clinical autonomy	93	99	97	100	100	100	98	99

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Section Five: PHYSICAL FACTORS

Brief explanation: ***Quality patient care is facilitated by appropriate physical structures. The practice premises, including its facilities and equipment, should be adequate for the needs of the practice and should be maintained in a safe condition.***

Standard 5.1 Practice facilities

The practice has facilities which are appropriate for general practice and which promote the health, safety and comfort of staff and people who use the practice.

Criterion★5.1.1

The practice has one dedicated consulting/examination room for every doctor working in the practice at any one time. Each room has adequate and appropriate amenities for the comfort, privacy and safety of patients and others.

Results for this criterion in the Field Test:

Practice compliance:

All practices met this criterion by each assessment method (Table 5.1A). Agreement between joint and self assessment was 88%, and between principal and second surveyor 91% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 5.1G). The criterion was acceptable to 93% of practices and 98% of surveyors. Smaller practices were more likely to agree that this was an acceptable criterion. All solo practices, 96% of small and only 88% of large practices found this acceptable (χ^2=10.76,df=4,p=0.03) (Table 5.1H). The criterion was seen as achievable by 95% of surveyors and 98% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★5.1.1 Indicators:

☐ ***A.*** **(direct observation)*.***

☐ ***B. Patients feel comfortable in the consultation rooms*** **(patient survey)*.***

☐ ***C. The practice meets criterion 2.1.2.***

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion★5.1.2

Each consultation room has adequate and appropriate facilities for patient assessment during the consultation process.

Results for this criterion in the Field Test:

Practice compliance:

Virtually all practices met this criterion by each assessment method (Table 5.1A). Agreement between joint and self assessment was 94%, and between principal and second surveyor 96% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 5.1G). The criterion was acceptable to 97% of practices and 98% of surveyors (Table 5.1H) and was seen as achievable by 97% of surveyors and 98% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ✭5.1.2 Indicators:

☐ ***A. The consultation room is free from excessive extraneous noise*** **(direct observation).**

☐ ***B. There is adequate lighting in the consultation room*** **(direct observation).**

☐ ***C. There is an examination couch in each consultation room*** **(direct observation).**

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion 5.1.3

The practice has a patient waiting area sufficient to accommodate the usual number of patients and others who would be waiting at any one time.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 5.1A). Agreement between joint and self assessment was 91%, and between principal and second surveyor 96% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 98% of practices and surveyors (Table 5.1G). The criterion was acceptable to 93% of practices and 91% of surveyors (Table 5.1H) and was seen as achievable by 85% of surveyors and 98% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ✭5.1.3 Indicators:

☐ ***A.*** **(direct observation).**

☐ ***B. Patients feel comfortable in the waiting room*** **(patient survey).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion★5.1.4

The practice has toilets and hand washing facilities readily available for use by patients and others.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion for each assessment method (Table 5.1A). For joint assessment there was a significant association between RARA and assessment of this criterion (χ^2=11.49,df=4,p=0.02) because the 3% of practices which did not meet this criterion were all from RARA 1/2 (Table 5.1C), and a higher proportion of practices from RARAs 3/5 were judged as scoring 'partial' rather than 'substantial.' (Table 5.1E). Agreement between joint and self assessment was 93%, and between principal and second surveyor was 93% (Table 5.1B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 98% of practices and surveyors (Table 5.1G). The criterion was acceptable to 98% of practices and 98% of surveyors (Table 5.1H) and was seen as achievable by 90% of surveyors and 99% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★5.1.4 Indicators:

☐ ***A.*** **(direct observation)**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion□5.1.5

The practice provides privacy for patients and others in distress.

Results for this criterion in the Field Test:

Practice compliance:

Over 97% of practices met this criterion for each assessment method (Table 5.1A). For joint assessment there was a significant association between RARA and level of achievement on this criterion (χ^2=9.92,df=4,p=0.04). This was due to the higher proportion of practices from RARAs 4/6 'partially' meeting this criterion (Table 5.1E). Practices with less than 4 doctors were more likely to fail this criterion by joint assessment (4%) than practices with 4 doctors or more who all passed (χ^2=5.56,df=1,p=0.02) (Table 5.1C). Agreement between joint and self assessment was 91%, and between principal and second surveyor 97% (Table 5.1B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

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Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 98% of practices and surveyors (Table 5.1G). The criterion was acceptable to 92% of practices and 95% of surveyors (Table 5.1H) and was seen as achievable by 90% of surveyors and 96% of practices(Table 5.1I). Although an overall significant relationship between practice size and agreement with achievability was observed, this was mainly an effect of solo doctors choosing 'don't know'. There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ✭5.1.5 Indicators:

☐ ***A. (doctor interview, staff interview, direct observation)***

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion 5.1.6

The practice has a telecommunications system adequate to its needs.

Results for this criterion in the Field Test:

Practice compliance:

Over 97% of practices met this criterion for each assessment method (Table 5.1A). Agreement between joint and self assessment was 87%, and between principal and second surveyor 94% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

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Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 5.1G). The criterion was acceptable to 93% of practices and 95% of surveyors (Table 5.1H) and was seen as achievable by 91% of surveyors and 98% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 5.1.6 Indicators:

☐ ***A. The practice has a telephone system with sufficient inward and outward call capacity* (direct observation, staff interview, patient survey).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in the surveyor workshops.

Criterion 5.1.7

The practice has adequate and appropriate secure storage for medical records, patient files and other records.

Results for this criterion in the Field Test:

Practice compliance:

Almost all practices met this criterion by each assessment method (Table 5.1A). Agreement between joint and self assessment was 87%, and between principal and second surveyor 91% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 98% of practices and surveyors (Table 5.1G). The criterion was acceptable to 94% of practices and 97% of surveyors (Table 5.1H) and was seen as achievable by 88% of surveyors and 96% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 5.1.7 Indicators:

☐ ***A.*** **(direct observation)**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion 5.1.8

Practice security is maintained at all times.

Results for this criterion in the Field Test:

Practice compliance:

Over 93% of practices met this criterion for each assessment method. However, practices were more likely to have failed this criterion by joint assessment (6%) than by self assessment (1%) (χ^2=6.98,df=1,p=0.01) (Table 5.1A). By joint assessment solo practices were less likely to meet this criterion than other practices, 14% of solo practices being judged to have failed this criterion compared to 3% of all other practices (χ^2=7.75,df=1,p<0.01) (Table 5.1C). Agreement between joint and self assessment was 67%, and between principal and second surveyor 81% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 5.1G). The criterion was acceptable to 87% of practices and 93% of surveyors (Table 5.1H) and was seen as achievable by 95% of surveyors and 96% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 5.1.8 Indicators:

☐ ***A. Drugs of dependency are safely secured (eg in a locked cupboard or safe) and adequately documented as required by state regulations*** **(direct observation)*.***

☐ ***B. Other drugs are securely stored*** **(direct observation)*.***

☐ ***C. Prescription pads, letterhead and other official documents are not accessible to unauthorised persons*** **(direct observation)*.***

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

A point was made in the WA surveyor group that “drugs should not be just adult safe, they should also be child safe.”

The NSW group suggested adding the requirement for the practice to have a fire extinguisher.

Criterion★5.1.9

The practice has appropriate facilities or arrangements for sterilisation, disinfection and decontamination.

Results for this criterion in the Field Test:

Practice compliance:

Over 93% of practices met this criterion for each assessment method. By joint assessment 7% of practices would have not met this criterion compared to 1% by self assessment

(χ^2=12.46,df=1,p<0.01) (Table 5.1A). By joint assessment practices from RARAs 4/6 (99%) were more likely to meet this criterion than were practices from other RARAs (89%) (χ^2=10.36,df=1,p<0.01) (Table 5.1C). Solo practices, by joint assessment, were less likely to meet this criterion than were other practices, 16% of solo practices failing to meet this criterion compared to 3% of other practices (χ^2=8.19,df=1,p<0.01) (Table 5.1C). Agreement between joint and self assessment was 74%, and between principal and second surveyor 86% (Table 5.1B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice and as being acceptable by almost all practices and surveyors (Table 5.1G). Solo practices (χ^2=5.80,df=1,p=0.02) and practices in RARA 4/6 (χ^2=5.70,df=1,p=0.02) were less likely to regard this criterion as acceptable than other practices (Table 5.1H). The criterion was seen as achievable by 76% of surveyors and 92% of practices (Table 5.1I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★5.1.9 Indicators:

☐ ***A. The practice has facilities for hand washing in each consulting room*** **(direct observation)*.***

☐ ***B. The doctor(s) and staff can describe procedures undertaken for sterilisation / disinfection / decontamination of surfaces*** **(doctor interview, staff interview)*.***

☐ ***C. The doctor(s) and staff can describe procedures undertaken for sterilisation / disinfection / decontamination of equipment*** **(doctor interview, staff interview)*.***

☐ ***D. The practice has appropriate equipment and materials for decontamination*** **(direct observation)*.***

☐ ***E. The practice has an arrangement for "off-site" sterilisation of equipment*** **(doctor interview, staff interview, documents and other records)*.***

☐ ***F. Other (specify) .....***

Note:	*Sterilisation/Disinfection Guidelines for General Practice* (RACGP Practice Management Committee of Council, RACGP, 1991) may be of interest.

Comments on Indicators by Surveyors:

This criterion was discussed at each surveyor workshop because it had been left deliberately vague in the standards, as at the time of writing the standards the guidelines relating to sterilisation were undergoing a major review. Several new criteria, developed by the Standards Development Unit for discussion, were briefly reviewed at the workshops. These were supported by all surveyors.

Criterion ★5.1.10

The practice has provision for the safe disposal of contaminated waste.

Results for this criterion in the Field Test:

Practice compliance:

By self assessment 97% of practices met this criteria and 84% by joint assessment (Table 5.1A). Agreement between joint and self assessment was 69%, and between principal and second surveyor 86% (Table 5.1B).

There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by over 97% of practices and surveyors (Table 5.1G). The criterion was acceptable to 96% of practices and 95% of surveyors (Table 5.1H) and was seen as achievable by 76% of surveyors and 94% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★5.1.10 Indicators:

☐ ***A. The doctor(s) and staff are aware of, and implement, appropriate methods of contaminated waste disposal* (doctor interview, staff interview).**

☐ ***B. There is a designated and appropriate container for contaminated waste* (direct observation).**

☐ ***C. Other (specify) .....***

Note:	*National Guidelines for the Management of Clinical and Related Wastes* (National Health & Medical Research Council, Canberra, 1988) may be helpful here.

Comments on Indicators by Surveyors:

The SA surveyor group suggested re-wording the criterion to read:

The practice has provision for, and safely disposes of, hazardous waste.

The WA group argued that because laws and regulations vary from region to region, this criterion should be non-essential. They felt that the criterion and indicators were too vague and were therefore difficult to assess. The group felt that the proposed revision was a considerable improvement.

Surveyors in several groups asked how a surveyor can determine compliance with this criterion "when every local government has different regulations". Surveyors were also concerned with instances where the local government does not have any policy on this issue or their regulations would not be considered acceptable in the *Entry Standards*. Surveyors requested advice from the Standards Reference Group as to what surveyors should tell the practice and how to maintain consistency between all practice visits. Surveyors suggested that the standards should be explicit in their requirements.

Surveyors also noted that a recent study had found that the contaminated waste from GP surgeries was not as contaminated as normal household garbage. Some surveyors argued that many regulations that are placed on GP surgeries are onerous and unnecessary.

Criterion ★5.1.11

The practice has provision for the safe disposal of 'sharps' both within the practice, and from the practice to final destruction.

Results for this criterion in the Field Test:

Practice compliance:

Over 97% of practices met this criterion for each assessment method (Table 5.1A). Relatively more solo practices (10%) than other practices (1%) rated themselves (self assessment) as having 'partially' met this criterion (χ^2=9.38,df=1,p<0.01) (Table 5.1F). Agreement between joint and self assessment was 92%, and between principal and second surveyor 97% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and by all surveyors (Table 5.1G). The criterion was acceptable to 99% of practices and 100% of surveyors (Table 5.1H) and was seen as achievable by 95% of surveyors and 98% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ✭5.1.11 Indicators:

☐ ***A. The doctor(s) and staff are aware of, and implement, appropriate methods of 'sharps' disposal*** **(doctor interview, staff interview).**

☐ ***B. There is a designated and appropriately labelled 'sharps' container. The container is designed and constructed so as to minimise the possibility of injury to handlers*** **(direct observation).**

☐ ***C. Other (specify) .....***

Note:	*National Guidelines for the Management of Clinical and Related Wastes* (National Health & Medical Research Council, Canberra, 1988) may be useful here.

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion 5.1.12

The practice implements strategies to ensure the safety and comfort of doctors and staff.

Results for this criterion in the Field Test:

Practice compliance:

By self assessment 95% of practices met this criterion as did 93% by joint assessment (Table 5.1A). Solo practices did not meet this criteria by joint assessment in 14% of instances compared to 5% of other practices (χ^2=4.39,df=1,p=0.04) (Table 5.1C). Agreement between joint and self assessment was 49%, and between principal and second surveyor 73%. (Table 5.1B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 97% of practices and surveyors (Table 5.1G). The criterion was acceptable to 90% of practices and 91% of surveyors (Table 5.1H) and was seen as achievable by 79% of surveyors and 95% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 5.1.12 Indicators:

☐ ***A. The practice has clear procedures for manual handling (ie lifting of heavy objects etc)*** **(doctor interview, staff interview, direct observation).**

☐ ***B. The practice provides counselling regarding risks of infection to female staff of child bearing age*** **(doctor interview, staff interview).**

☐ ***C. All staff are offered immunisation appropriate for their situation*** **(doctor interview, staff interview).**

☐ ***D. The practice has a sharps injury protocol*** **(doctor interview, staff interview, documents and other records).**

☐ ***E. Office equipment is properly designed for its purpose (eg chairs are adjustable)*** **(direct observation).**

☐ ***F. The practice implements universal precautions for the control of infection eg wearing gloves when taking blood samples*** **(doctor interview, staff interview, direct observation).**

☐ ***G. Other (specify) .....***

Comments on Indicators by Surveyors:

A majority of surveyors in both the NSW and Vic groups felt that there were some significant problems with the indicators for this criterion. In both groups Indicator A was seen as inappropriate - the surveyors said they found the question in the protocol difficult because practices "laughed in our face".

The NSW group felt that the criterion should be rewritten to say that "there is a clear procedure for observing occupational health and safety requirements". They also felt that indicators B, D and F should be compulsory, ie should become criteria in their own right.

In Vic it was felt that indicator B (counselling for female staff) was 'antiquated'. One surveyor suggested that the RACGP should issue guidelines on counselling and needlestick injury.

Criterion★5.1.13

The practice is well maintained and visibly clean.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion for each assessment method (Table 5.1A). Agreement between joint and self assessment was 91%, and between principal and second surveyor 96% (Table 5.1B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.1A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by almost all practices and surveyors (Table 5.1G). The criterion was acceptable to 95% of practices and 98% of surveyors (Table 5.1H) and was seen as achievable by 96% of surveyors and 99% of practices (Table 5.1I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★5.1.13 Indicators:

☐ ***A.*** **(direct observation).**

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Table 5.1A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
5.1 Practice facilities				
*5.1.1 one consultation room per doctor	100	100	100	100
*5.1.2 facilities in consultation room	100	100	100	100
5.1.3 waiting area	100	100	99	100
*5.1.4 toilets/hand washing facilities	99	100	99	98
*5.1.5 privacy for distressed	98	99	97	98
5.1.6 telecommunications system	98	100	97	97
5.1.7 medical & other records storage	100	99	100	99
5.1.8 practice security	**94[1]**	**99**	94	96
*5.1.9 sterilisation, disinfection...	**93[2]**	**100**	94	94
*5.1.10 contaminated waste disposal	84	97	86	87
*5.1.11 sharps disposal	98	100	98	97
5.1.12 safety of doctors & staff	93	95	93	93
*5.1.13 well maintained, visibly clean	99	100	98	99

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria. [1] Practices were more likely to have not met this criterion by joint assessment compared to self assessment (χ^2=6.98,df=1,p=0.01). [2] Practices were more likely to have not met this criterion by joint assessment compared to self assessment (χ^2=12.46,df=1,p<0.01).

Table 5.1B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
5.1 Practice facilities		
*5.1.1 one consultation room per doctor	88	91
*5.1.2 facilities in consultation room	94	96
5.1.3 waiting area	91	96
*5.1.4 toilets/hand washing facilities	93	93
*5.1.5 privacy for distressed	91	97
5.1.6 telecommunications system	87	94
5.1.7 medical & other records storage	87	91
5.1.8 practice security	67	81
*5.1.9 sterilisation, disinfection...	74	86
*5.1.10 contaminated waste disposal	69	86
*5.1.11 sharps disposal	92	97
5.1.12 safety of doctors & staff	49	73
*5.1.13 well maintained, visibly clean	91	96

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 5.1C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.1 Practice facilities	**79**	**77**	**80**	**83**	**68**	**77**	**88**
*5.1.1 one consultation room per doctor	100	100	100	100	100	100	100
*5.1.2 facilities in consultation room	100	99	100	100	98	100	100
5.1.3 waiting area	100	100	100	98	100	100	99
*5.1.4 toilets/hand washing facilities	99	**97[1]**	**100**	**100**	98	97	100
*5.1.5 privacy for distressed	98	96	98	100	**94[2]**	**97[2]**	**100**
5.1.6 telecommunications system	98	99	96	96	98	98	96
5.1.7 medical & other records storage	100	99	100	100	98	100	100
5.1.8 practice security	94	97	92	92	**86[3]**	**95**	**99**
*5.1.9 sterilisation, disinfection...	93	**93**	**90**	**98[4]**	**84[5]**	**95**	**98**
*5.1.10 contaminated waste disposal	84	83	84	85	75	84	88
*5.1.11 sharps disposal	98	98	96	98	96	98	98
5.1.12 safety of doctors & staff	93	93	94	92	**86[6]**	**94**	**94**
*5.1.13 well maintained, visibly clean	99	98	100	100	98	98	100

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] There was a significant association between RARA and assessment of this criterion (χ^2=11.49,df=4,p=0.02). [2] Practices with less than 4 doctors were more likely to fail this criterion (χ^2=5.56,df=1,p=0.02). [3] Solo practices were less likely to meet this criterion than other practices (χ^2=7.75,df=1,p<0.01). [4] Practices from RARAs 4/6 were more likely to meet this criterion than were practices from other RARAs (χ^2=10.36,df=1,p<0.01). [5]Solo practices were less likely to meet this criterion than were other practices. (χ^2=8.19,df=1,p<0.01). [6] Solo practices were less likely to meet this criterion than were other practices. (χ^2=4.39,df=1,p=0.04).

Table 5.1D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.1 Practice facilities	**96**	**95**	**98**	**96**	**96**	**94**	**98**
*5.1.1 one consultation room per doctor	100	100	100	100	100	100	100
*5.1.2 facilities in consultation room	100	100	100	100	100	100	100
5.1.3 waiting area	100	100	100	100	100	100	100
*5.1.4 toilets/hand washing facilities	100	99	100	100	100	98	100
*5.1.5 privacy for distressed	99	98	100	98	98	97	100
5.1.6 telecommunications system	100	99	100	100	100	98	100
5.1.7 medical & other records storage	99	99	100	98	98	98	100
5.1.8 practice security	99	100	98	98	100	100	98
*5.1.9 sterilisation, disinfection...	**100**	99	100	100	100	98	100
*5.1.10 contaminated waste disposal	97	97	98	98	98	97	98
*5.1.11 sharps disposal	100	100	100	100	100	100	100
5.1.12 safety of doctors & staff	95	94	98	96	98	91	98
*5.1.13 well maintained, visibly clean	100	100	100	100	100	100	100

Table 5.1E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.1 Practice facilities							
*5.1.1 one consultation room per doctor	91	88	90	98	86	94	92
*5.1.2 facilities in consultation room	96	96	94	98	92	97	98
5.1.3 waiting area	96	98	94	94	98	94	96
*5.1.4 toilets/hand washing facilities	90	**93**	**82**[1]	**92**	88	86	94
*5.1.5 privacy for distressed	93	**95**	**94**	**90**[2]	86	92	99
5.1.6 telecommunications system	90	93	86	88	92	89	89
5.1.7 medical & other records storage	91	90	92	94	90	89	94
5.1.8 practice security	74	75	74	71	68	70	80
*5.1.9 sterilisation, disinfection...	71	63	76	81	56	66	83
*5.1.10 contaminated waste disposal	72	66	76	79	60	67	82
*5.1.11 sharps disposal	93	93	92	94	88	94	95
5.1.12 safety of doctors & staff	58	64	50	54	55	48	68
*5.1.13 well maintained, visibly clean	93	93	90	96	88	92	96

[1] There was a significant association between RARA and assessment of this criterion (χ^2=11.49,df=4,p=0.02). This was an effect of a higher proportion of practices from RARAs 3/5 being judged as scoring 'partial' rather than 'substantial.' [2] There was a significant association between RARA and level of achievement on this criterion due to the higher proportion of practices from RARAs 4/6 'partially' meeting this criterion.(χ^2=9.92,df=4,p=0.04).

Table 5.1F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.1 Practice facilities							
*5.1.1 one consultation room per doctor	95	96	96	94	92	95	98
*5.1.2 facilities in consultation room	99	99	96	100	98	97	100
5.1.3 waiting area	93	97	90	88	88	92	96
*5.1.4 toilets/hand washing facilities	93	97	88	92	94	89	96
*5.1.5 privacy for distressed	93	94	94	90	90	92	95
5.1.6 telecommunications system	93	95	100	96	98	92	99
5.1.7 medical & other records storage	92	92	94	90	90	91	94
5.1.8 practice security	67	71	67	59	61	64	73
*5.1.9 sterilisation, disinfection...	86	85	88	87	81	78	94
*5.1.10 contaminated waste disposal	83	80	86	84	73	79	90
*5.1.11 sharps disposal	97	97	100	94	**90**[1]	**98**	**100**
5.1.12 safety of doctors & staff	48	53	55	32	51	47	48
*5.1.13 well maintained, visibly clean	93	93	94	92	90	89	98

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Solo practices were less likely than other practices to rate themselves as having 'substantially' met this criterion (χ^2=9.38,df=1,p<0.01).

Table 5.1G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.1 Practice facilities								
*5.1.1 one consultation room per doctor	100	99	100	98	100	100	98	100
*5.1.2 facilities in consultation room	100	99	99	98	100	100	96	100

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.1.3 waiting area	98	98	99	96	100	98	96	100
*5.1.4 toilets/hand washing facilities	98	99	100	98	100	98	100	100
*5.1.5 privacy for distressed	100	98	98	96	100	93	98	100
5.1.6 telecommunications system	100	99	100	98	98	95	100	100
5.1.7 medical & other records storage	100	98	99	96	98	98	98	97
5.1.8 practice security	100	99	99	100	98	98	98	100
*5.1.9 sterilisation, disinfection...	98	99	100	98	100	98	100	100
*5.1.10 contaminated waste disposal	98	97	99	91	100	93	98	99
*5.1.11 sharps disposal	100	99	100	98	100	100	98	100
5.1.12 safety of doctors & staff	97	97	96	96	100	95	94	100
*5.1.13 well maintained, visibly clean	100	99	100	98	100	98	100	100

Table 5.1H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.1 Practice facilities								
*5.1.1 one consultation room per doctor	98	93	95	91	93	**100**	**96**	**88**[1]
*5.1.2 facilities in consultation room	98	97	96	96	100	100	96	96
5.1.3 waiting area	91	93	94	96	90	95	91	94
*5.1.4 toilets/hand washing facilities	98	98	99	98	98	95	100	99
*5.1.5 privacy for distressed	95	92	93	91	90	90	96	89
5.1.6 telecommunications system	95	93	96	91	90	95	91	94
5.1.7 medical & other records storage	97	94	95	91	95	95	94	93
5.1.8 practice security	98	94	94	96	93	93	94	94
*5.1.9 sterilisation, disinfection...	98	97	**96**	**100**	**95**[3]	**90**[2]	**98**	**100**
*5.1.10 contaminated waste disposal	95	96	96	91	100	93	96	97
*5.1.11 sharps disposal	100	99	100	96	100	98	98	100
5.1.12 safety of doctors & staff	91	90	93	82	95	88	87	94
*5.1.13 well maintained, visibly clean	98	95	95	93	97	93	92	99

[1] Large practices were less likely to agree that this was an acceptable criterion. Only 88% of large practices found this acceptable (χ^2=10.76,df=4,p=0.03). Both solo practices[2] (χ^2=5.80,df=1,p=0.02) and practices in RARA 4/6[3] (χ^2=5.70,df=1,p=0.02) were less likely than other practices to regard this criterion as acceptable.

Table 5.1I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.1 Practice facilities								
*5.1.1 one consultation room per doctor	95	98	98	98	100	97	96	100
*5.1.2 facilities in consultation room	97	98	98	98	100	100	94	100
5.1.3 waiting area	85	98	100	96	98	98	98	99
*5.1.4 toilets/hand washing facilities	90	99	99	100	100	98	100	100
*5.1.5 privacy for distressed	90	96	94	100	95	**88**	**96**	**100**
5.1.6 telecommunications system	91	98	99	98	98	95	98	100
5.1.7 medical & other records storage	88	96	95	98	95	93	96	97
5.1.8 practice security	95	96	95	100	93	95	96	96
*5.1.9 sterilisation, disinfection...	76	92	90	96	95	88	92	96
*5.1.10 contaminated waste disposal	76	94	94	93	95	93	93	96
*5.1.11 sharps disposal	95	98	100	96	95	98	96	99
5.1.12 safety of doctors & staff	79	95	94	96	98	93	93	99
*5.1.13 well maintained, visibly clean	96	99	98	100	100	95	100	100

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Standard 5.2 Practice equipment

Medical equipment and resources are appropriate and adequate to ensure comprehensive primary care and resuscitation. These are adequately maintained and checked.

Criterion★5.2.1

The practice has medical equipment necessary to ensure comprehensive primary care and resuscitation. (There is a large range of equipment that practices may, and perhaps should, have. The equipment a practice actually has will depend on the type of practice and the interests and styles of the doctors in it.)

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion for each assessment method (Table 5.2A). A significant association between size of practice and level of achievement of this criterion was observed for joint assessment (χ^2=9.65,df=4,p=0.05). Larger practices were more likely to be rated as 'substantially' meeting this criterion (Table 5.2E). Agreement between joint and self assessment was 92%, and between principal and second surveyor 95% (Table 5.2B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 98% of practices and surveyors. Solo practices (7%) were more likely to 'disagree' with the statement that this criterion reflected good general practice compared to other practices who all 'agreed' (χ^2=8.60,df=1,p<0.01) (Table 5.2G). The criterion was acceptable to 93% of practices and 94% of surveyors (Table 5.2H) and was seen as achievable by 83% of surveyors and 96% of practices (Table 5.2I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★5.2.1 Indicators:

☐ ***A. The practice has the following:***

a. Stethoscope;

b. Auriscope;

c. Ophthalmoscope;

d. Sphygmomanometer;

e. Peak flow meter;

f. Vaginal speculum;

g. Thermometer;

h. Scales;

i. Urine testing strips;

j. Patella hammer;

k. Eye charts;

l. Equipment for maintaining an airway in both adults and children (eg Guedel airways);

m. Equipment to assist ventilation (eg AMBU bag or similar);

n. Disposable needles.

(direct observation)

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion ★ 5.2.2

The practice ensures that each doctor has access to a 'doctors bag'. The doctors bag contains minimal equipment, drugs and stationery for diagnosis of common and urgent problems, treatment of emergencies and common problems necessitating home visits, referral to hospital and other services.

Results for this criterion in the Field Test:

Practice compliance:

Over 90% of practices met this criterion for each assessment method. (Table 5.2A). Agreement between joint and self assessment was 63%, and between principal and second surveyor 83% (Table 5.2B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 98% of practices and surveyors (Table 5.2G). The criterion was acceptable to 97% of practices and surveyors (Table 5.2H) and was seen as achievable by 91% of surveyors and 96% of practices. Practices in RARA 4/6 were more likely to 'disagree' that the criterion was achievable (χ^2=4.53,df=1,p=0.03) (Table 5.2I). There were no other significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★ 5.2.2 Indicators:

☐ ***A. The doctors bag contains a stethoscope, auriscope, ophthalmoscope, sphygmomanometer, equipment for maintaining an airway, drugs for medical emergencies, syringes and needles in a variety of sizes, a torch and stationery (including prescription pads and letterhead)*** **(direct observation).**

☐ ***B. Drugs carried are checked regularly to ensure that their "use by date" has not expired*** **(doctor interview, staff interview, direct observation).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

One WA surveyor remarked that practices as a whole rarely take responsibility for individual doctor's bags. It was argued that the criterion was difficult to measure and that many rural GPs do not have a bag. This criterion was felt to be better as an indicator under home visits. A NSW surveyor had a similar thought suggesting that doctor's bags should contain "home visit vouchers for inclusion in the medical records."

Criterion ★ 5.2.3

The practice has appropriate vaccine storage which maintains vaccines at temperatures between 2°C and 8°C.

Results for this criterion in the Field Test:

Practice compliance:

By self assessment 94% of practices would have met this criterion compared to just 81% for joint assessment (χ^2=15.05,df=1,p<0.01) (Table 5.2A). Agreement between joint and self assessment was

51%, and between principal and second surveyor 78% (Table 5.2B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 99% of practices and 95% of surveyors (Table 5.2G). The criterion was acceptable to 96% of practices and 93% of surveyors (Table 5.2H) and was seen as achievable by 85% of surveyors and 97% of practices (Table 5.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★5.2.3 Indicators:

☐ ***A. Vaccines are stored in a separate or an infrequently used refrigerator, ie. a refrigerator not used for other purposes such as storing lunches etc*** **(direct observation, staff interview).**

☐ ***B. There is accurate monitoring of the temperature within the refrigerator - eg a cold chain monitor card or a maximum/minimum thermometer*** **(direct observation).**

☐ ***C. Other (specify) .....***

Comments on Indicators by Surveyors:

One surveyor suggested that this criterion can be easily measured by the surveyors bringing their own thermometer. It was pointed out however that the critical issue was not the temperature at the time of the visit (although this should be recorded) but that the appropriate temperature is maintained and monitored continuously. Some members of the WA group suggested removing the requirement that lunches not be stored with the vaccines.

Criterion ★5.2.4

The practice has equipment appropriate to the procedures performed in the practice.

Results for this criterion in the Field Test:

Practice compliance:

Virtually all practices met this criterion by each assessment method (Table 5.2A). Agreement between joint and self assessment was 96%, and between principal and second surveyor also 96% (Table 5.2B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by all practices and surveyors (Table 5.2G). The criterion was acceptable to 99% of practices and all surveyors (Table 5.2H) and was seen as achievable by 98% of surveyors and all practices (Table 5.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion ★5.2.4 Indicators:

☐ ***A.*** **(direct observation)**

☐ ***B. Other (specify) .....***

Note:	For those practices which regularly undertake procedures, *Standards for Office Procedures in General Practice* (RACGP Practice Management Committee of Council, RACGP 1992) would be useful.

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Criterion 5.2.5

The practice has access to a range of resources and reference materials for immediate reference.

Results for this criterion in the Field Test:

Practice compliance:

By joint assessment, 94% of practices met this criterion and by self assessment, 97%. (Table 5.2A). Agreement between joint and self assessment was 51%, and between principal and second surveyor 80% (Table 5.2B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.2A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 98% of practices and surveyors (Table 5.2G). The criterion was acceptable to 90% of practices and 88% of surveyors (Table 5.2H) and was seen as achievable by 85% of surveyors and 98% of practices (Table 5.2I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 5.2.5 Indicators:

☐ ***A. The practice has a range of recent medical and surgical texts*** **(direct observation).**

☐ ***B. The practice has an organised system of access to appropriate GP journals*** **(doctor interview, direct observation).**

☐ ***C. The practice has a computerised access system for medical information*** **(doctor interview, direct observation).**

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

The Vic group suggested that indicator C should be deleted, because it is a duplication of indicator B as computers are an 'organised system'.

Table 5.2A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
5.2 Practice equipment				
*5.2.1 medical equipment	99	100	99	99
*5.2.2 doctors bag	92	98	90	91
*5.2.3 vaccine storage	**81**[1]	**94**	83	81
*5.2.4 equipment for procedures	100	100	100	100
5.2.5 resources and reference materials	94	97	94	94

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria. [1] Significantly less practices met this criterion by joint assessment compared to self assessment (χ^2=15.05,df=1,p<0.01).

Table 5.2B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
5.2 Practice equipment		
*5.2.1 medical equipment	92	95
*5.2.2 doctors bag	63	83
*5.2.3 vaccine storage	51	78
*5.2.4 equipment for procedures	96	96
5.2.5 resources and reference materials	51	80

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 5.2C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.2 Practice equipment	**77**	**80**	**74**	**73**	**76**	**75**	**78**
*5.2.1 medical equipment	99	98	100	98	**98**	**98**	**99**
*5.2.2 doctors bag	92	95	88	92	88	92	95
*5.2.3 vaccine storage	81	81	82	81	82	80	82
*5.2.4 equipment for procedures	100	100	100	100	100	100	100
5.2.5 resources and reference materials	94	95	96	92	92	95	95

Table 5.2D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.2 Practice equipment	**92**	**94**	**98**	**82**	**94**	**91**	**92**
*5.2.1 medical equipment	100	100	100	100	100	100	100
*5.2.2 doctors bag	98	99	100	94	98	97	99
*5.2.3 vaccine storage	94	95	98	88	96	94	93
*5.2.4 equipment for procedures	100	100	100	100	100	100	100
5.2.5 resources and reference materials	97	96	98	98	100	97	95

Table 5.2E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.2 Practice equipment							
*5.2.1 medical equipment	92	88	96	96	**84**[1]	**90**[1]	**98**
*5.2.2 doctors bag	68	76	59	63	64	70	69
*5.2.3 vaccine storage	41	40	40	42	42	34	45
*5.2.4 equipment for procedures	99	98	98	100	96	98	100
5.2.5 resources and reference materials	71	70	70	75	74	72	69

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Larger practices were more likely to be rated as 'substantially' meeting this criterion (χ^2=9.65,df=4,p=0.05).

Table 5.2F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.2 Practice equipment							
*5.2.1 medical equipment	95	95	96	96	96	94	96
*5.2.2 doctors bag	82	84	79	79	80	82	83
*5.2.3 vaccine storage	63	63	64	61	70	60	60
*5.2.4 equipment for procedures	98	99	98	96	94	100	99
5.2.5 resources and reference materials	57	51	68	59	64	48	60

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 5.2G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.2 Practice equipment								
*5.2.1 medical equipment	98	98	99	98	98	**93**[1]	**100**	**100**
*5.2.2 doctors bag	98	98	99	98	98	95	98	100
*5.2.3 vaccine storage	95	99	100	98	100	100	100	99
*5.2.4 equipment for procedures	100	100	100	100	100	100	100	100
5.2.5 resources and reference materials	98	98	100	100	93	93	100	100

[1] Solo practices were more likely to disagree with the statement that this criterion reflected good general practice (χ^2=8.60,df=1,p<0.01).

Table 5.2H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.2 Practice equipment								
*5.2.1 medical equipment	93	94	95	91	93	90	98	92
*5.2.2 doctors bag	97	97	98	96	98	95	96	99
*5.2.3 vaccine storage	93	96	98	93	95	92	98	96
*5.2.4 equipment for procedures	100	99	99	98	100	95	100	100
5.2.5 resources and reference materials	88	90	93	91	83	83	91	93

Table 5.2I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.2 Practice equipment								
*5.2.1 medical equipment	83	96	95	98	95	90	98	97
*5.2.2 doctors bag	91	96	**98**	**98**	**93**[1]	95	96	97
*5.2.3 vaccine storage	85	97	98	98	95	100	96	96
*5.2.4 equipment for procedures	98	100	100	100	100	100	100	100
5.2.5 resources and reference materials	85	98	98	100	95	95	98	99

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion. [1] Practices in RARA 4/6 were more likely to regard this criterion as not achievable (χ^2=4.53,df=1,p=0.03).

Standard 5.3 Physical access

The practice services are physically accessible.

Criterion 5.3.1

The practice provides appropriate physical access to the practice and its facilities including access for people with disabilities.

Results for this criterion in the Field Test:

Practice compliance:

By joint assessment, 96% of practices met this criterion and by self assessment 99%. (Table 5.3A). Agreement between joint and self assessment was 72%, and between principal and second surveyor 84% (Table 5.3B). There were no significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.3A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 97% of practices and surveyors. There was a significant association between practice size and the response to the statement that this reflects good practice. Solo practices were more likely to 'disagree' (9%) with the statement compared to other practices (nil) (χ^2=13.74,df=4,p<0.01) (Table 5.3G). The criterion was acceptable to 86% of practices and 84% of surveyors. Excluding those practices who responded 'don't know', 16% of solo practices disagreed with the acceptability of this compared to 4% of other practices (χ^2=5.14,df=1,p=0.02) (Table 5.3H). The criterion was seen as achievable by 70% of surveyors and 91% of practices (Table 5.3I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion 5.3.1 Indicators:

☐ ***A. There is adequate parking within a reasonable distance from the practice*** **(direct observation)*.***

☐ ***B. There is wheelchair access to the practice and its facilities, ie to consultation and examination rooms, toilets etc*** **(direct observation)*.***

☐ ***C. The practice has ramps, railings, accessible toilets etc to assist people with disabilities*** **(direct observation)*.***

☐ ***D. Other (specify) .....***

Comments on Indicators by Surveyors:

The Vic group argued that the indicators should be flexible - older practices could not be expected to meet this criterion immediately. An indicator should be added stating that there should be sufficient access for an ambulance stretcher to gain entry to the practice.

It was pointed out by some that surveyors were quite generous on this criterion, passing practices that "barely met it".

Criterion★5.3.2

Where physical access is limited, the practice provides off-site visits to patients with disabilities.

Results for this criterion in the Field Test:

Practice compliance:

Over 98% of practices met this criterion for each assessment method (Table 5.3A). However 13% of practices from RARAs 1/2 considered this to be 'not applicable' compared to 5% in other RARA areas (χ^2=3.95,df=1,p<0.05). Agreement between joint and self assessment was 74%, and between principal and second surveyor 92% (Table 5.3B). There were no other significant differences in achievement related to RARA or the size of practice, by either assessment method (Tables 5.3A-F).

Assessment of criterion:

The criterion was regarded as reflecting good general practice by 99% of practices and 98% of surveyors (Table 5.3G). The criterion was acceptable to 94% of practices and 98% of surveyors (Table 5.3H) and was seen as achievable by 95% of surveyors and 99% of practices (Table 5.3I). There were no significant differences in face validity, acceptability or achievability related to RARA or the size of practice.

Criterion★5.3.2 Indicators:

☐ ***A.*** **(doctor interview, staff interview)*.***

☐ ***B. Other (specify) .....***

Comments on Indicators by Surveyors:

These indicators were not raised for discussion in any of the surveyor workshops.

Table 5.3A Criterion met by assessment method (%)

Standard / Criterion	Jt	Sl	Pr	Sd
5.3 Physical access				
5.3.1 appropriate physical access	96	99	96	97
*5.3.2 off site visits (limited access)	100	98	99	100

Jt = joint assessment, Sl = self assessment, Pr = principal surveyor, Sd = second surveyor, * = essential criteria.

Table 5.3B Inter-rater reliability by assessors (% agree)

Standard / Criterion	J/S	P/S
5.3 Physical access		
5.3.1 appropriate physical access	72	84
*5.3.2 off site visits (limited access)	74	92

J/S = joint Vs self assessment, P/S = principal surveyor Vs second surveyor, * = essential criteria.

Table 5.3C Joint assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.3 Physical access	**100**	**99**	**100**	**100**	**98**	**100**	**100**
5.3.1 appropriate physical access	96	95	98	96	94	97	96
*5.3.2 off site visits (limited access)	100	99	100	100	98	100	100

Table 5.3D Self assessment by RARA and practice size (% met)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.3 Physical access	**98**	**97**	**98**	**100**	**98**	**97**	**99**
5.3.1 appropriate physical access	99	98	100	100	100	98	99
*5.3.2 off site visits (limited access)	98	97	98	100	98	97	99

Table 5.3E Joint assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.3 Physical access							
5.3.1 appropriate physical access	73	71	72	79	60	80	76
*5.3.2 off site visits (limited access)	89	**83**[1]	**96**	**94**	86	91	89

[1] More practices from RARAs 1/2 considered this to be 'not applicable' compared to other areas and therefore less rated as 'substantial' (χ^2=3.95,df=1,p<0.05).

Table 5.3F Self assessment by RARA and practice size (% substantial)

Standard / Criterion	All	R1	R3	R4	So	2+	4+
5.3 Physical access							
5.3.1 appropriate physical access	72	70	78	69	64	67	80
*5.3.2 off site visits (limited access)	81	83	74	83	76	80	84

All = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

Table 5.3G Response to "This criterion reflects good..practice" (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.3 Physical access								
5.3.1 appropriate physical access	97	97	99	93	97	**91**[1]	**98**	**100**
*5.3.2 off site visits (limited access)	98	98	100	96	100	98	98	100

[1] Solo practices disagreed with the statement that this criterion reflects good practice more frequently than other practices (χ^2=13.74,df=4,p<0.01).

Table 5.3H Response to: "This criterion is acceptable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.3 Physical access								
5.3.1 appropriate physical access	84	86	84	84	93	**76**[1]	**83**	**94**
*5.3.2 off site visits (limited access)	98	94	94	93	97	92	93	97

[1]Solo practices disagreed with the acceptability of this relitively more often than other practices (χ^2=5.14,df=1,p=0.02).

Table 5.3I Response to: "This criterion is achievable..." (% agree)

Standard / Criterion	Su	Pr	R1	R3	R4	So	2+	4+
5.3 Physical access								
5.3.1 appropriate physical access	70	91	90	96	85	88	89	93
*5.3.2 off site visits (limited access)	95	99	99	98	100	97	98	100

Su = surveyors, Pr = all practices, R1 = RARA areas 1&2, R3 = RARA 3&5, R4 = RARA 4&6, So = solo practices, 2+ = 2-3 person practices, 4+ = practices with greater than 4 persons, * = essential criterion.

CHAPTER 6

DISCUSSION

The Entry Standards, the assessment methodology and the results of the Field Test must be viewed in the context of the accreditation model developed by the RACGP Standards Working Party (SWP) in 1992. The philosophical approach was derived from both a review of the literature regarding other approaches to standards development and accreditation already discussed in Chapter 2 and an acute awareness of the political and professional atmosphere at the time. The introduction of vocational registration in 1989 had caused considerable turmoil within general practice and the wider medical profession. By 1992 many of the concerns expressed by some GPs and voiced by the Australian Medical Association, were still unresolved. The RACGP Council had survived two extraordinary general meetings, called by members to reverse some of the changes negotiated by the College with the government. Accreditation was perceived by some GPs to be an additional bureaucratic burden rather than an initiative to improve the quality of care. The RACGP and its SWP were therefore anxious to reinforce the professional and quality aspects of the accreditation proposal and to address GP concerns.

The basic College philosophy, which was reflected in the earlier development of its quality assurance and continuing medical education program, was that quality development in general practice should be under the control of the profession. The College was committed to improving quality of care through involvement of GPs in the quality development process. The accreditation model was therefore designed to be:

- inclusive, that is to involve as many practices as possible;
- based on a model of peer review;
- concerned with raising standards rather than penalising practices;
- concerned initially with minimum standards;
- educational with an emphasis on formative rather than summative assessment;
- an entry point to a process of continuous quality improvement.

The model therefore strongly influenced the SWP approach to development of the Entry Standards and the assessment methodology. These in turn inevitably influenced the results of the Field Test.

Entry Standards for the Field Test

The Entry standards were developed using an extensive consensus process amongst GPs and GP organisations. While other groups were consulted, such as the Consumers' Health Forum and the Department of Human Services and Health (DHSH), their contribution to the Entry Standards was given significantly less weight than the feedback from GPs. The SWP model determined that the standards had to be acceptable to GPs if they were to be used for a peer review process. One disadvantage of this approach was that the standards were perceived by consumer advocates to be too doctor oriented and to have insufficient 'client focus'.

The consensus process thus resulted in standards which were attuned to the ethos of GPs, their view of what aspects of practice were important, what was acceptable to measure and what was achievable in the Australian practice context. Given the SWP model of a process that led into continuous quality assurance such a starting point had a certain face validity.

The ability of the standards to discriminate between 'good' and 'bad' practices was questioned by Tyson in a consultancy for the DHHLGCS.[90] He questioned the presence of some standards criteria which were likely to be met by all practices and would therefore discriminate poorly. The countervailing view taken by SWP was that a set of standards serves the dual purpose of an

assessment process and a reference document of those standards which the profession regards as important. Therefore, provided the standards themselves are valid, the fact that all practices meet some of them does not render them redundant. Criteria which were considered vital indicators of quality were designated 'essential' (ie had to be met if a practice was to pass assessment). The ability to discriminate was not considered a mandatory attribute of 'essential' criteria.

Method

As discussed above in relation to the development of standards, the assessment methodology grew out of the SWP model of accreditation as a peer review process. While in terms of practice staff, medical receptionists and practice managers could be considered 'peers', the Field Test only utilised GPs as surveyors. Other 'demonstration trials' of standards and accreditation were funded by DHSH with the particular aim of testing assessment methodologies which may be used in a future accreditation system.[91] The demonstration trials tested the use of practice managers/receptionists/nurses as surveyors, in addition to GPs, in a process that was conducted in parallel to the Field Test.

Sampling

As described in Chapter 4, Method, the size and stratification of the practice sample was based on statistical advice from the (then) Family Medicine Research Unit (FMRU) at the University of Sydney who had considerable experience in research sampling in general practice.[92] The FMRU advice was that the sample size of 200 stratified to 100 metropolitan, 50 large rural and 50 small rural practices would allow sufficient statistical power to allow discrimination between practices and between geographic strata. The stratification for 'rurality' had the expected effect of providing a sufficiently wide spectrum of practices of varying size to allow discrimination between three strata of size. While there were logistical consideration (mainly monetary) limiting the size of the sample, the research team had a reasonable level of confidence in the methodology used to determine the sample. This was in spite of the difficulty with sample size determination in a research process without comparable precedent. The level of discrimination of the instrument was unknown. The variance between practices in the areas to be investigated was also an unknown quantity. Past experience of the FMRU had suggested that a GP sample size of greater than 40 was sufficient to compensate for individual variance and this was a reasonable basis on which to select the minimum strata size for practices. Epi Info, with a hypothetical research discrimination model, was used to confirm the probable adequacy of the sample size at the level of granularity proposed for statistical analysis.[77] Tyson, in a consultancy for DHHLGCS, suggested that a larger sample of 370 would give greater discrimination and correct for under representation of metropolitan practices.[90] However advice from the FMRU suggested that a very much larger sample size would be necessary to significantly increase the statistical power of the analysis. A paper prepared jointly by the Standards Development Unit and the FMRU set out the statistical basis for the sample size and the statistical analysis of collected data.[93]

By all the tests undertaken, the final sample was representative of Australian general practice. There was a higher level of agreement to participate among RACGP members and by group and rural practices. However there is no reason to believe that the different levels of agreement influenced the results of the Field Test.

Assessment method

Patient survey

Input from patients was appropriate in the assessment of some of the criteria in the standards. As it was not logistically possible to design a process specifically for the Field Test in the time available, a pre-existing patient questionnaire developed by the RACGP for quality assurance purposes was used. The design of the Field Test was modified to allow the practices twice the estimated time required for practices to undertake the survey, send the forms to the RACGP Research and Health Promotion Unit, and receive a report.

In spite of the time allowed many practices had not completed their survey forms by the day of the visit, while others had completed the forms but had not yet received a report from the Unit. It is estimated (from observer and surveyor reports) that survey results were only available in 20-25% of practices on the day of the visit.

Logistically therefore it must be concluded that incorporation of the survey was not a success within the time-frame of the field test.

Difficulties were also experienced by surveyors in interpreting the results.

"Some of the questions did not seem relevant to standards." (Surveyor, WA)

"The presentation of data was not easily interpreted - some was positive and some was negative." (Surveyor, Vic)

"This survey has some problems. The questions are not very relevant." (Surveyor, Qld)

"The survey needs much better correlation with any standards assessment or accreditation process. I also think it is a bit too long and complicated." (Surveyor, NSW)

"Information about practices was often very sketchy and incomplete." (Surveyor, SA)

Despite the difficulties experienced, it was clear that a patient survey or some other process involving patients could be a useful part of practice assessment as it would provide a further tool for the evaluation of general practices, because of its acceptability to practices and because surveyors perceived patient data as valuable:

"I never saw a patient survey. Practices which had agreed to participate had either not sent them in yet or if they had been sent in, had not had the results sent back. It was a pity as I believe consumer views would have been relevant." (Surveyor, WA)

The Patient Participation Programme survey has been a successful and valuable QA option for many years. It was however concluded that the survey, in its current form, is not well suited to the needs of external surveyors assessing practices against the Entry Standards.

Additional questions in the current survey or a specifically designed questionnaire that relates directly to the standards document would be required for future practice visits. The development of such a questionnaire would require considerable expertise and a thorough understanding of the standards.

A workshop, sponsored by DHSH, at which the standards and assessment process were reviewed, was held following the Field Test.[94]

Continuing concerns regarding the orientation of the standards and the perceived lack of consumer input led the Consumer Health Forum (CHF) to commission two reports which were released in 1996. The first, 'Integrating Consumer Views about Quality in General Practice' by Stewart-Weeks et al, identified, quantified and classified a range of issues of concern to patients.[95] It showed that many of the attributes of general practice valued by consumers are attributes of the individual practitioner with whom they interact rather than the practice. Thus technical competence and interpersonal skills rate highly. While it might be argued that such attributes are not properly the province of standards for practices they may not be picked up by other quality improvement mechanisms and therefore consideration needs to be given to including some of these aspects of care in future accreditation mechanisms. The failure of the patient survey in the Field Test makes consideration of alternative mechanisms for patient input essential.

In considering patient input it is important, as it is with peer measured standards, to link the standards being measured to the measurer's perception of quality. If patient input is to be truly integrated into practice there must be a shared perception between patients and practice about the value of the process to both parties. There needs to be an acceptance by GPs that attributes important to patients should be built into the standards and assessment.

This process is not without considerable complexity. Stewart-Weeks demonstrated that patient perceptions of quality were context and problem dependent so that, for example, a consultation length of 10 minutes may be ample for one problem and an hour barely sufficient for another. Interpersonal skills and continuity may not be highly valued by an adolescent with a 'cold' and short waiting times may not be a high priority to a pensioner with chronic arthritis. Designing standards which take such complexity into account presents a continuing challenge to GPs and their patients.

In 1998, before the implementation of accreditation of Australian general practices, the Patient Participation Programme questionnaire was modified to include questions related to all the standards for which criteria specified patient input. A second, alternative questionnaire, was also approved for

use in obtaining feedback from patients. Completion of a patient survey is currently mandatory before a practice accreditation survey visit is undertaken.[96]

As I stated in Chapter 2, one quality development process cannot be expected to address all the quality issues in general practice. Further research is needed to determine if consumer views can be successfully and meaningfully integrated into accreditation standards using these questionnaires or an alternative approach.

Results

Validity of the criteria

Face validity

As might be expected from the extensive consultation and consensus process used for the development of the standards and criteria, there was a high level of agreement In the Field Test that the criteria reflected good general practice.

The lowest levels of agreements (although still very high) related to standards of patient communication and access. Four of the five criteria (1.2.1, 1.2.4, 1.2.5, and 1.2.6) related to various aspects of communication such as the provision of written materials regarding the practice and health problems, information about the costs of care, and communication with patients who may require interpreters. Good communication is an important attribute of the doctor-patient relationship and is regarded as a high priority by patients. However the criteria in Standard 1.2, with the exception of consultation length, do not equate with the type of doctor-patient communication in the consultation, such as listening and discussing treatment, highly regarded by patients.[95]

The lowest score for 'reflected good general practice' (59%) was given by solo practices to the criteria requiring patient information sheets. Small practices (less than 4+ GPs) were all less likely to agree that provision of practice information sheets reflected best practice. This perhaps reflects a closer personal relationship between doctor and patient in small practices and a perception that verbal communication renders information sheets unnecessary.

The latter form of communication with patients is strongly supported by consumer advocates and became a legal requirement for practices in Commonwealth privacy legislation which came into force in December 2001, many years after the Field Test. The legislative requirements are set out in the RACGP 'Handbook for the management of health information in private medical practice'[97] and in the Federal Privacy Commissioner's 'Guidelines on Privacy in the Private Health Sector'.[98] However it was not an issue raised by patients in the CHF research mentioned above.[95] The concentration on the practices' communication strategy, as distinct from practitioner communication skills, may therefore be misplaced.

Other GP peer review processes have included 'sitting in' on consultations to gauge the quality of the doctor patient interaction[54]. While adding such a process to the accreditation visit would make the assessment both more complex and threatening (as you would have to examine every doctor in the practice), it could add significantly to the value from a patient viewpoint. An alternative may be to use videotapes of consultations in the accreditation process as is done in the Performance Based Assessment process for the FRACGP.[99]

Such a videotape process would also allow qualitative evaluation of the adequacy of consultation length that could be added to the quantitative limit on the number of consultations per hour stated in the first indicator for this criterion. This could supplement patient survey information regarding the consultation which could be collected in a redeveloped patient questionnaire. The latter however may be biased by learned low expectations of the patient. The consultation length criterion was also one of the few rated below 90% by practices although at 89% it had high support. The importance of consultation length in the provision of quality care has recently been re-emphasised by Freeman et al.[100] Consultation length is both a function of the communication style of the practitioner and the content and context of the consultation. Simple numeric data from observation of an appointment schedule or health insurance claims data are insufficient to assess the quality of the consultations. Assessment of more complex data sets extracted from electronic health records may offer an alternative approach in the future. However in the medium term peer review may be the most valid approach.

Some differences in perception of the validity of some criteria arose in rural and small practices. In the case of rural practices this sometimes appeared to relate to workforce issues of practitioner supply and resulting limitations on available time. In particular, practices in RARA 3 & 5 were less likely to perceive advice by telephone, consistency within the practice and keeping a current health summary as reflecting good practice. This may reflect a different style of practice in rural centres brought about by a different relationship to hospitals and other health professionals in these locations.

Similarly solo practices are constrained financially in terms of equipment purchase and regarded equipment as less important as a measure of quality. Solo practitioners were less likely to view the provision of medical equipment and good physical access as necessary for good practice, perhaps reflecting these economic constraints. Incentives for the amalgamation of practices included in the general practice reform strategy of the Australian Federal Government may change this situation by reducing the numbers of solo GPs. However those that continue will have ongoing financial constraints.

Content validity: comprehensiveness of the standards

There were very few suggestions for additional standards and criteria, again suggesting that the development process had been comprehensive. However a theme emerged regarding the need for subsets of standards to address issues in particular types of practices.

A significant deficiency noted by both practices and surveyors related to rural practices and their relationship to country hospitals. In very small towns the hospital may be a virtual extension of the practice but the accreditation process bid not cover this area. Similarly the hospital accreditation process of the ACHS does not cover the reciprocal relationship. While this issue only applies to a small and decreasing number of practices it has important implications for rural practice and therefore needs to be addressed, possibly by the development of supplementary standards for rural practices.

The need for subsets of standards for practices undertaking specific activities also arose in regard to teaching and research practices. A minority of practices undertake these activities. However such activities raise important issues in regard to privacy and patient consent. The RACGP has a separate set of standards for practices that undertake vocational training of GP registrars and practices are assessed against these standards in a separate accreditation process.[101] University Departments of General Practice also have a separate process for accrediting practices teaching medical undergraduates. These three processes could well be brought together by the development of supplementary standards for rural, teaching and research practices which could be assessed at the same time as basic practice standards.

The other significant area identified by both practices and surveyors was that of doctors' health, particularly in terms of ensuring sufficient holidays are taken and limiting the length of working hours. This is a subset of more general issues of occupational health and safety which could apply to all practice employees. Occupational health and safety issues are not well addressed in the current standards. Consideration should be given to improving coverage of this area as the standards and accreditation evolve.

Content validity: redundancy

Surveyors were also asked if there were standards or criteria that should be removed. While the suggestions were varied they mainly concerned criteria with lower scores for face validity or which did not discriminate well between practices.

In view of the generally high level of support for all of these criteria and the philosophy of including criteria even where they did not discriminate well, their removal is probably not justified.

Criterion validity: joint assessment and global judgement

One methodological difficulty of the Field Test was the lack of a validated alternative process against which the Field Test standards and assessment process could be compared. There is however a long history of the use of peer review processes in evaluating practice performance.[54;56] It was therefore decided to compare the result of the assessment process with a joint evaluation by the two practice surveyors of the overall quality of the practice. This was referred to as 'global judgement'. This judgement by two experienced practitioners has some face validity in its own right.

The surveyors regarded 8.4% of practices as not suitable for accreditation by global judgement. All of these practices failed the formal Field Test assessment process. However almost 40% (n=68) of practices that failed the formal assessment were judged worthy of a pass on global judgement. The practices were not given the opportunity in the Field Test to correct any deficiencies in practice performance against the standards before the surveyor visit. This was done to establish a baseline assessment of compliance. As discussed below under 'Assessment' most failed only one or two easily correctable criteria. The correction of these deficiencies in a developed accreditation process could be expected to occur before a practice assessment visit.

The global judgement may take into account qualitative aspects such as the 'ethos' of the practice and attitudes of the practitioners - qualities not easily assessed by the formal process. The problem of potential observer bias when measuring such qualitative aspects of general practice remains to be solved. The importance of these characteristics should stimulate a search for appropriate assessment methodology.

Acceptability

The scores for acceptability of the criteria were almost identical to those discussed above for face validity. There may be a close conceptual linkage in the minds of the practices and surveyors between a criterion's value as a measure of quality and its acceptability in a set of standards. While this question may thus be redundant it serves to emphasise the linkage between validity and acceptability.

Consistent with their perception that the provision of information sheets do not represent good practice, solo and 2-3 doctor practices were less likely to find this acceptable in a set of standards. Similarly good patient access was a less acceptable standard to solo practitioners. Solo practitioners were less inclined to find provision of respectful care acceptable in the standards even though they were no less inclined to view this as good practice. This may relate to the greater provision of services to specific ethnic groups by some solo practitioners where they may be selective on racial grounds. Similarly they did not see facilitation of patient transfer to other practices as acceptable as other practices. This perhaps reflects the closeness of the doctor-patient relationship in solo practice and a less frequent transfer of patients to other practices.

The provision of appropriate sterilisation equipment and procedures was also less acceptable to solo practitioners, again possibly reflecting the economic constraints of equipment purchase in solo practice.

More doctors in RARAs 3 & 5 and 4 & 6 had concerns with the provision of non urgent access to a doctor within two days, reflecting the effect of a higher work load. Some RARA 3 & 5 doctors had concerns with the provision of written health information possibly reflecting the difference in practice style referred to above.

Like solo practitioners, practitioners in RARA 1 & 2 and 4 & 6 were less likely to rate sterilisation equipment as an acceptable standard. This may reflect a wider concern with the economic cost involved in the provision of modern sterilisation equipment. Achievability

There is little point in producing a set of standards if they cannot be achieved by those to whom they apply. The large majority of practices regarded all the criteria as achievable in their practice. The surveyors were much less optimistic regarding the achievement of some criteria by practices overall.

Surveyors' assessment of achievability dropped below 50% for practices' ability to meet the criteria for the provision of health summaries in medical records. They were also pessimistic regarding the practices' ability more generally to improve the information in medical records. Although there is little evidence of a direct linkage between the quality of medical records and the quality of care delivered by a GP, the absence of adequate records makes analysis of quality of care extremely difficult. The College of Physicians and Surgeons in Ontario, Canada has suggested that poor records should be regarded as prima facia evidence of poor care.[102;103] In Australia, the Commonwealth Privacy Act, the NSW Medical Practitioners Act and the Victorian Health Records Act all place statutory requirements on GPs to maintain adequate records. Many GPs have traditionally regarded their medical records as an 'aide memoir' rather than a complete record of data collected. Yet there is a clear professional, community and government perception that doctors' medical records should be accurate and complete. The accreditation process, recent legislation and increasing computerisation of practices

may facilitate the cultural change necessary to address the problem of achieving high quality records in general practice.

The surveyors also rated the achievability of practice cooperation with local health programs much lower than did the practices. This may be due to a perception that external providers of health programs need to be both present and cooperative for practices to achieve this requirement.

Rural practices were concerned about the achievability of criteria such as early availability of appointments, availability of a doctor of choice and provision of preventive care. Achievability of access to a doctor of choice was a particular concern of some doctors in RARA 4 & 6. The small number of doctors in some of these areas may effectively limit patient choice. These issues of access and the provision of some services perceived by the practices as optional may relate to the workforce deficiency in Australian rural general practice which limits the available time of rural general practitioners. System problems may therefore limit the ability of some practices to meet standards. This should be taken into account in the assessment process. The demonstrated effect of workforce deficiencies on quality should stimulate the system changes necessary to address these problems.

Provision of a doctors bag was seen as less achievable by doctors in the RARA 4 & 6 small rural and remote areas. Many rural doctors carry emergency equipment in their cars and/or use hospital emergency areas to treat patients outside their surgery, removing the necessity for the traditional doctors bag.

Solo practitioners were less likely to rate as achievable the provision of a doctor of choice reflecting the fact that there is no choice as to which doctor you can see in a solo practice.

Provision of areas in the practice for distressed patients was also seen as less achievable by solo practitioners who work out of more limited accommodation than group practitioners.

Like their rural colleagues, more large practices perceived access to consultations within two days as less achievable than smaller practices. The reason for this perception is unclear.

Large practices less frequently rated provision of one consultation room per doctor as achievable. This may reflect doctors, particularly part time practitioners, in larger practices using the same rooms at different times of attendance. The number of consulting rooms would therefore reflect the number on duty at any one time rather than the number working in the practice.Some services, such as interpreters for patients of non-English speaking background, are dependent on third party suppliers and may also be beyond the capacity of the practice to alter, particularly in areas where this group is small and interpreters infrequently required.

The achievement of some criteria is clearly dependent on factors outside practice control. Practice circumstances need to be taken into account when failure to meet those criteria would lead to withholding accreditation. Flexibility is essential, particularly in relation to rural and remote practices.

Assessment

Of 199 participating practices, 55% met all essential criteria. Of the 45% not meeting all essential criteria, three quarters met all but one or two. This result may reflect the fact that practices were asked not to make any special preparations for the assessment visit. As practices would undertake greater preparation in a ‘real’ accreditation system, it is anticipated that a substantially greater number of practices would meet all essential criteria. It is possible that approximately 85-90% of practices could meet the standards in such a system. This would be in line with the results of the Global Assessment by surveyors.

Overall 58 of the 65 criteria were met by more than 90% of participating practices. Of the seven criteria with the lowest levels of achievement, five were non-essential. The two essential criteria least likely to be met were those relating to contaminated waste disposal (84% met this criterion) and vaccine storage (81%). Yet both of these criteria were rated by practices as highly acceptable and achievable in a set of minimum standards.

Several criteria were identified as requiring review on the basis of compliance, acceptability or perceived achievability by practitioners or surveyors. These included vaccine storage, sterilisation, contaminated waste disposal, medical records, patient information sheets, staff support, use of interpreter services, and discussion of costs and risks with patients. All of these criteria were carefully

reviewed by the SDU and the SWP. They were regarded as sufficiently important to include, with minor modification, in the 1996 Standards subsequently developed from the Field Test standards.[104]

Relationship of assessment and RARA and practice size

One of the important aims of the Field Test was to determine if the standards and accreditation process discriminated against rural or solo practices.

While there were no statistical differences related to RARA or practice size in the final outcome by self assessment, joint assessment or global judgement there appeared a trend towards poorer performance by solo practices.

For individual criteria this difference in solo practices reached statistical significance for confidentiality of records, privacy of patients, practice security, sterilisation, safety of staff, medical equipment and practice information sheets. However it was only for the last of these that the difference was of sufficient magnitude to be of practical significance in an accreditation process. The provision of practice information sheets is a straightforward process which should not discriminate in a developed accreditation system.

With the multiple comparisons undertaken in the Field test there are undoubtedly cases where the statistically significant difference is due to a Type 2 error. It is therefore important to consider the relevance of some of the differences when they are of no practical significance in determining the outcome of the whole process.

In relation to rurality of practices, RARA 1 and 2 (metropolitan) practices performed less well in relation to involvement in local health programs and RARA 1, 2, 3 and 5 (metropolitan and large rural areas) practices performed less well in regard to sterilisation and disinfection procedures. The differences were both of sufficient magnitude to potentially alter the outcome of accreditation for these groups.

In Australia local health programs are organised by State authorities. The relationship between practices and these programs can be difficult in the metropolitan areas. In the rural areas the general practitioners are more closely involved with local health authorities and hospitals and integration is therefore easier. The difficulty in practices complying with criteria that are dependent on the external providers of programs was discussed previously. The relationship of health system characteristics to the delivery of quality primary care is discussed later in this chapter.

Sterilisation and disinfection procedures are an important quality issue in practices in an era when blood born disease has increased exponentially. The conventional wisdom that post operative infection is rare in office based practice can no longer justify sub-standard practice. An accreditation process may provide an effective mechanism to raise standards in this area.

Reliability

It is essential that any assessment process should have demonstrable reliability in the application of the assessment instrument.

Reliability of the instrument was measured by comparing joint with self assessment and principal with second surveyor. There was substantial agreement between principal and second surveyor but only slight agreement between self and joint assessment.

The higher inter-rater reliability between surveyors compared to that of joint and self assessment may in part be explained by the circumstances of the methods of assessment. The self assessment and joint assessments were not undertaken at the same time. Practices may have implemented changes as a consequence of the self assessment process. Measurement bias, introduced by practices overstating their compliance with the standards could also account for some of the differences in reliability.

The higher reliability of the surveyors' assessments may in part be explained by the fact that the assessments were completed simultaneously by two surveyors with equally impartial views on the standards they were observing. Bias may have been introduced into the process (as reported on rare occasions by observers) through surveyors changing their scores after consulting with each other.

This would have improved the inter-rater reliability. Unfortunately the extent to which this occurred cannot be accurately estimated.

As many of the criteria require subjective interpretation and assessment, the surveyors' attitudes could cause a bias in the assessment given by the surveyor. The Field Test process used a surveyor training program to aid standardisation of interpretation and to 'normalise' the approach of surveyors to the assessment process, thus reducing bias. This may also have been a contributing factor in the good inter-rater reliability between surveyors and should be continued in any established accreditation process.

For individual criteria the agreement between surveyors was less than 80% in respect to 11 criteria. This was measured as the level of absolute agreement on one of the four possible scores using a four by four table analysis. Disagreement was frequently based on the applicability of the criteria in a practice or of a judgement of substantial or partial agreement. When converted into a two by two pass/fail analysis almost all the differences disappeared to give the high reliability described above. This means that there was far more disagreement between surveyors regarding the applicability of criteria or the extent to which a practice met a criteria, than as to whether a practice should pass or fail a criteria.

The self assessment process may continue to be a useful formative process for practices wishing to undertake accreditation. When used by a practice to detect deficiencies for correction before summative assessment by external surveyors, the self assessment may well yield a different result from that in the Field Test, as the different purpose may lead practices to be more self critical.

Value of accreditation

In assessing the value of accreditation systems for the Department of Health in the United Kingdom, Scrivens (1997)[105] defined accreditation as "a means of assessing the organisational process and performance using agreed-upon standards, compliance with which is assessed by surveyors". This definition brings together the common elements of most healthcare accreditation schemes: the definition of performance domains; development of (usually consensus) standards; and the process of assessment using 'surveyors'.

The development of general practice accreditation was based on the premise that the structural, organisational and process elements of a general practice have a significant effect on the quality of patient care and patient outcomes. This premise evolved from a realisation, discussed in the background to this thesis, that quality of care has many facets and needs to be addressed in multiple ways if continuing improvement is to be achieved.

Assessment of the value of an accreditation process can be approached from several directions. Different groups, such as providers, health care funders, consumers, the public and policy makers, will have different perceptions of various aspects of accreditation.

Many areas of the process can be candidates for assessment. These include the standards themselves, the motivational effect of practice involvement in the accreditation process, the benefit of the surveyor visit, the effect on risk management, and the stimulation of organisational change and the stimulation of innovation.[105]

In the Field Test assessment of the standards relied on perceptions of the practices and the surveyors. Most accreditation systems use professional perception to validate standards and to measure outcomes of the process.[105]

Scrivens reported that managers with experience in organisational accreditation felt that the impact of accreditation was only in terms of attitudes towards quality or cultural change within the organisation. Changed attitudes regarding quality and cultural change are an essential prerequisite for effective quality management systems and if accreditation achieves nothing more than this the benefit may still be significant.

It may however be difficult to establish causal relationships between accreditation and improvement in quality. As discussed in Chapter 2, such difficulties in attribution of the effect of quality initiatives are common across the health care system. Ram et al attempted to establish the relationship between the structural characteristics of general practices and some process attributes of consultations in the practices and found the relationship to be weak.[106] They suggested that structure and process may

be independent predictors of quality or that they measure different aspects of quality. Thus, for example, structural problems may limit patient access to care in situations where the quality of the care provided is very good to the few who can access it. The quality in community and equity terms may therefore be deemed poor.

The Donabedian model of a linear or sequential relationship between structure, process and outcome, with each dependent on the other[57] is conditional on the causal relationship between the elements. In fact all three can behave as independent factors in the attainment of quality when viewed from a global community perspective. The 'best' quality may follow from high quality structure, process and outcome contributing independently to the final result. As a consequence assessments of structural quality such as accreditation need to be evaluated independently of process and outcome as well as being evaluated jointly to measure system quality. Therefore independent assessment of accreditation may need to go no further than indicators of compliance with the standards and analysis of the perceptions of the providers, patients and funders. Certainly, because there is no valid research to support a causal relationship between accreditation and good or bad practice process and outcomes, there is no justification for the use of process or outcome measures to evaluate accreditation.

The educational value of the assessment process was demonstrated in the Field Test by the positive responses of practices and surveyors, and by the substantial number of changes, either undertaken or planned, as a result of the Field Test.

Accreditation in the context of quality primary care

As suggested above, an accreditation process for general practice has the potential to address an important aspect of quality in primary medical care. This component has been described as 'structure' by Donabedian[57] and as 'capacity' by Starfield.[107]

No matter how effective an accreditation system is in improving the 'capacity' of Australian general practice it will deliver only the potential to improve quality unless other components are also addressed.

Development of 'Quality Systems'

The SWP envisaged accreditation as a starting point for a process of continuous quality improvement in practices. However translating the concept of continuous quality improvement introduced by Deming to the manufacturing industry in post war Japan[108] has been painful and frustrating in the health and other service sectors.

The concepts inherent in Total Quality Management (TQM) and Continuous Quality Improvement (CQI) were translated into the International Standards Organization's 9000 series of standards for quality systems. The RACGP commissioned Foxwell Consulting in 1995 to undertake a comparison between the Entry Standards and the requirements of ISO 9002 "Quality Systems – Model for quality assurance in production, installation and servicing". The result demonstrated the difficulties, particularly in relation to the required documentation, in implementing these systems in a health service industry context when the individual business units are small.[109]

The Australian Council on Healthcare Standards 'Evaluation and Quality Improvement Program' (EQuIP) is an example of implementation of CQI concepts at the hospital level. While quality systems of this type may be applicable at the large organisational level, there is still scant evidence of their effectiveness.

While in primary care these concepts could build on the established quality assurance techniques of clinical audit and peer review, they have yet to demonstrate their ability to improve quality at the practice level.

Quality of 'process' or 'performance'

The second component of quality of care, labelled 'process' by Donabedian[57] and 'performance' by Starfield[107], is sometimes also called 'technical quality'. This refers to measurement of the disease management process largely in terms of the appropriateness and efficacy of management interventions.

Much of the quality assurance and quality improvement industry in health has been based on measures to improve quality and therefore outcomes by 'improving' management of disease by the use of 'evidence based medicine'.

The informational problems practitioners have in obtaining assistance from the literature, described by Williamson,[110] have increased under a flood of research data. This flood has been barely dented by the efforts of the Cochrane Collaboration to condense the evidence base of medicine through meta-analysis.

The Cochrane collaboration has concentrated almost exclusively on condensing information from randomised controlled trials (RCTs) conducted almost entirely in institution based medicine. These studies perforce use extensive exclusion criteria to remove confounding variables. Both the context and the RCT methodology make the resulting conclusions of questionable value or applicability in primary care. The lack of research into the effectiveness of much primary care therapy in the real world is a major hindrance in the development of evidence based medicine in primary care.

In spite of the efforts of David Sackett[111] and the Evidence-based Medicine Group[112] in systematising the process of critical appraisal, the lack of primary care evidence remains the critical stumbling block, along with the information overload, access problems, and the near impossible time constraints faced by most Australian primary care practitioners. Translation of these concepts into Australian general practice has thus been very difficult for even the most talented protagonists such as the late Chris Silagy.[113]

The 'missing link' in the 'evidence' is in the area of diagnostic process in primary care. General practitioners work in a context of low prevalence of serious disease and a high prevalence of undifferentiated problems. In 35% of general practice consultations in Australia the problem is undefined in terms of a disease label at the end of the diagnostic process[114]. The evidence base for the selection of diagnostic processes is much smaller and even less applicable than that for therapeutic interventions.[115;116]

Quality of 'outcome' or 'health status'

The interface between process and outcome is as blurred as that between structure and process. Indeed some desirable outcomes of care stem from the structure or capacity of primary care rather than the process. This is particularly the case when measuring attributes such as access and patient satisfaction.

Outcomes can be viewed from many perspectives, all of which need to be considered in any comprehensive overview of quality of care delivered by the primary care system. The outcomes of primary care in relation to population health and community aspirations are poorly documented in virtually all countries. Conventional primary medical care does not concern itself with the care of the population, only of those who seek care. Only a third of health problems arising in the community result in medical care and yet the other two thirds may have a significant impact on personal and community well being[117]. Tudor Hart demonstrated the impact on community health outcomes that could be achieved by taking a community (rather than individual) approach to care.[118] It is generally assumed that patient lists facilitate the community approach described by Hart. However in Norway, Grimsmo expressed concerns that the introduction of patient lists may adversely affect public health functions undertaken by primary health care doctors in that country.[119] Traditional roles must therefore be taken into account when advocating change.

Starfield uses the term 'health status' to group the 'whole patient' benefits of primary care such as perceived well-being, longevity and resilience.[107] These measures are more relevant to the whole of life approach of primary care than narrow disease oriented outcomes although these are important aspects of episodes of acute care. Health status measures can be used at both a patient and community level to measure the impact of primary care.

The WONCA/Dartmouth Coop charts are one attempt to measure these important aspects of monitoring the effectiveness of primary care at the individual level.[120] In spite of the support of the World organisation of Family Doctors, the uptake of the Coop charts has been very limited.

The United States National Committee on Vital and Health Statistics has suggested that health status measurement should become a requirement at every consultation with a health service provider.[107] However currently no widely accepted measurement methodology exists for this purpose. This

deficiency illustrates one more gap in our ability to measure and improve the quality of care delivered by primary care.

Structure of health systems and the quality of care

The functionality of primary care in a health system is dependent on the way in which primary care is regulated and funded. Just as 'capacity' (partly measured by accreditation) is essential to quality of care, a health system that facilitates and supports primary care is vital in achieving good health outcomes.

Starfield has identified 9 health system characteristics associated with good population health outcomes.107 These include:

1. Type of primary care system
2. Financing
3. Type of practitioner
4. Percent active physicians who are specialists
5. Professional earnings of primary care physicians relative to specialists
6. Cost sharing for primary care by patients
7. Existence of patient lists
8. Requirements for 24 hour coverage
9. Strength of academic departments of family medicine

Item 1 addresses issues of primary care resource distribution and consequent equity of access. In this respect Australia has a semi-regulated system which leaves gaps in rural and outer metropolitan areas. In contrast the UK has a regulated practice location system which scores well on this item.

Australia's universal health insurance system, use of trained general practitioners, equality of staffing between GPs and specialist, and low levels of patient co-payment score well in items 2-4 and 6.

Conversely the relatively poor earning of GPs, the absence of patient lists, lack of regulated requirements for 24 hour care and relatively weak academic departments of general practice score poorly.

On other features of general practices such as first contact care, longitudinality, comprehensiveness, coordination, family-centeredness and community orientation, Australia scores in the moderate range.

Overall Australia scores in the middle of the range for OECD countries, with public health indicators to match that status.

Primary care exists in a different cultural, social, economic and political milieu in each country. Processes that enhance primary care, such as the 'gate keeper' role and 'patient lists' may be perceived as unacceptable in some countries. However health authorities and the community should be aware of the potential price in terms of health outcomes caused by neglecting those features of primary care known to improve community health. Community and professional discussion of the merits of balanced gatekeeping[121] and patient lists[8] is needed to address the anxiety sometimes associated with these concepts.

All aspects of primary care at both the practice and system level must be addressed if we are to improve the quality of care to patient and community. This thesis has demonstrated that one aspect of quality in primary care can be successfully addressed.

CHAPTER 7

CONCLUSION

"If it is to improve, any discipline must be able to analyse itself so that it can develop its strengths and diminish its weaknesses" (Gray 1984)[122]

The Field Test demonstrated that the RACGP Entry Standards for General Practice were applicable and acceptable in general practices across Australia, and that the standards can be reliably assessed. A basis for an accreditation scheme has been created with the feasibility results of the Field Test (not reported in this thesis) giving an indication of time, resources and costs that could be expected in the full implementation of such a scheme.

The Field Test also demonstrated that the standards form a reliable assessment tool, appropriate for use in an accreditation system of the type envisaged by the RACGP's Standards Working Party.

Some issues and areas of difficulty needed to be addressed after the Field Test. These included: the nature of a 'partial' rating; aspects of the patient survey; ambiguous wording of certain criteria; and the role of the indicators.

The educational value of the assessment process was demonstrated by the positive responses of practices and surveyors, and by the substantial number of changes (either undertaken or planned) as a result of the Field Test. The Field Test showed that practices would welcome educational support to assist in achieving higher standards.

The development of general practice standards should be a continuing process in the future. Changing medical technology, medical treatment and changing expectations of both practitioners and patients creates the need for a dynamic and progressive process of standards development. The profession and its academic organisation such as the RACGP have a responsibility to ensure through self regulation that the profession delivers high quality of care to the Australian community.

This thesis has described the development and testing of just one aspect of the complex picture of quality in general practice. Much remains to be done.

EPILOGUE

Development of the 1996 Entry Standards for General Practices

A workshop, sponsored by DHSH, at which the standards and assessment process were reviewed, was held following the Field Test.[94] The results of the workshop together with the feedback from the Field Test, were used by the Standards Development Unit and the Standards Working Party (which was subsequently renamed the RACGP Standards Committee) to review the standards and develop the 1996 Entry Standards for General Practices for use in the accreditation process.[104]

The Field Test had shown that practices would welcome educational support to assist in achieving higher standards. In the developed accreditation program practices are given opportunity and support to make changes necessary to comply with the standards before an assessment visit. Most Australian Divisions of general practice now have support programs for practices preparing for accreditation.

Implementation of an accreditation system for general practice in Australia

The RACGP, the AMA, the RDAA, the AAGP and the Australian Divisions of General Practice (ADGP) formed Australian General Practice Accreditation Limited (AGPAL) to undertake the accreditation of general practices. The board of AGPAL contains representatives of the Government and consumers as well as representatives of the founding bodies.[123]

The Australian Government has made eligibility for grants to practices under the Practice Incentive Program dependent on the practice being accredited.[124] This provides an incentive of approximately $A10,000 per practitioner per year to practices that become accredited.

The first practice was accredited by AGPAL in August 1998. By December 2001, 3,740 Australian general practices had been accredited by AGPAL, approximately half of all eligible practices.[125]

As a result of this program to develop practice standards, validate their use in practices and develop an accreditation process, Australia has an effective system for progressive improvement in important structural and process components in general practices. This is a world first in addressing this important component of quality in general practice care.

Consequent developments in primary care accreditation in Australia and New Zealand

Subsequent to the development of general practice standards in Australia, the Royal New Zealand College of General Practitioners used the RACGP standards when developing a set of standards for accreditation of practices in New Zealand.[126]

In 1998 the Pharmaceutical Benefits Branch of the Australian Department of Health and Family Services funded the Department of Pharmacy, the University of Sydney and the School of Pharmacy and Medical Sciences, University of South Australia, in association with the Pharmaceutical Society and Pharmacy Guild, to develop standards of practice for pharmacies in Australia. These were also modelled on the RACGP practice standards.[127]

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Appendices

Appendix I	Entry Standards for General Practice - Draft for Field Test
Appendix II	Letter of invitation to participate in the Field Test
Appendix III	Letter of Instructions to Participating Practices
Appendix IV	Self Assessment Instructions
Appendix V	Information Sheets about the Practice Visit
Appendix VI	Practice Quality Assurance Points Form
Appendix VII	Patient Survey Form
Appendix VIII	Confidential Practice Doctor Questionnaire
Appendix IX	Surveyor Details Questionnaire
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