

# Appendix 2

## Background to development<sup>14</sup>

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### Introduction

*Aiming for Excellence* – the RNZCGP assessment instrument for general practice accreditation and quality improvement by practice teams – is now seven years old. It was developed for general practice, by general practice teams and those who use its services. It complements the College's Maintenance of Professional Standards programme for individual GPs, and identifies measurable standards of essential and desirable care by practice organisations and practice teams. The practice standards for essential care specify what is minimally required of the practices that voluntarily seek accreditation (official approval or endorsement). The standards for desirable care guide improvements in practice systems and clinical care pathways. *Aiming for Excellence* thus meets requirements of the New Zealand Public Health and Disability Act 2000 for the development, use and monitoring of nationally consistent standards and quality programmes for health services and patient safety.

*Aiming for Excellence* has focused on how practices deliver care to patients in the setting of New Zealand general practice. However, the nature and scope of general practice has been changing. Over the past two decades, an international debate has been 'rethinking the interface and the relationships between population health and primary health care, including general medical practice' [15]. In response to this debate, general practice has stayed central to the provision of primary health care but is now explicitly situated by Government policy in the primary health care system, with responsibilities to individual and families and to communities.

Since 2001, this policy context has been given voice by the Primary Health Care Strategy [16], which asks general practices, supported by Primary Health Organisations, to contribute to the local, coordinated delivery of accessible, longitudinal and comprehensive primary health care for individuals and enrolled populations. With needs-based funding, practice teams are expected to work in culturally appropriate ways with patients, local communities and other health and non-health agencies to improve primary health care provision; advance, maintain and restore people's health; and identify and reduce health inequalities. Practice teams are also expected to meet their obligations under the Treaty of Waitangi – *Tiriti o Waitangi*. Other societal changes, such as population aging and the diffusion of advances in knowledge and information technology among diverse groups, have in turn contributed to developments like chronic disease management, including self-care.

Accordingly, this revised version of *Aiming for Excellence* measures whether practice organisations are helping to deliver personal health care and population health care, including screening, other preventative health services and health promotion. It identifies key managerial, organisational and clinical approaches that practices need (a) to identify and build their own capacity and performance in the context of their relationships with stakeholders in the health system and other sectors; and (b) to be publicly accountable in support of coordinated changes for maximising the independence and health outcomes of individuals and communities. The designation of these communities moves beyond the clinical need of individuals to include priority population groups – such as Maori, as *tangata whenua*; Pacific peoples; and New Zealanders with high relative socioeconomic deprivation – that each underuse primary care services in proportion to their health needs.

*Aiming for Excellence* consists of five sections. Across these sections are a total of 49 indicators. Each indicator describes a measurable element of practice performance for which there is evidence that it can be used to assess the quality, and change in the quality, of care provided [17].

Each practice's level of performance on the individual indicators can be compared against the College *standard*. This standard or mark of success describes the College requirement for practices' level of compliance with each indicator. Therefore, the indicators define the RNZCGP standard for general practices in New Zealand. *Criteria* measure each indicator (and thus each standard). These are the elements, or single acts, of care that are so clearly defined that they can be counted or measured to help reveal whether the indicator was met or not [17]. Criteria are, therefore, discrete, definable, measurable and explicit. *Aiming for Excellence* consists of three categories of criterion measurement:

- ★★ Those that identify legal and safety obligations or significant risk as defined by the College. (Minimum Standards)

- ★ Considered best practice and important by the College (Essential)
- ☆ Those that identify opportunities for CQI (Desirable Standards).  
They define best practice, are maximally achievable, and are recommended by the profession but which are not essential for the purpose of accreditation.

The first two categories describe essential criteria. Criteria are essential if there is no real disagreement as to their necessity. In contrast, desirable criteria are considered important by most groups, as reflected for example in policy statements, but are not yet so important as to be deemed essential. For example, desirable criteria can accommodate some dissent over the role and responsibility of general practice for a population approach to health care, including providing (or collaborating with others who provide) preventative care and health promotion activity. As noted above, the Primary Health Care strategy [16 18] instrumentalises social forces redefining this role for New Zealand general practice [19 20]. However, attempts to broaden the nature and scope of the discipline of general practice have also been questioned in New Zealand [21] and internationally [24 26]. Thus, indicators relating to population health care are arguably desirable rather than essential to meet.

## Background

The development of *Aiming for Excellence* is the result of an historical partnership between stakeholder groups including General Practitioners, NZNO, PMAANZ, Maori and consumer representatives, Primary Health Organisations, District Health Boards, Ministry of Health and Accident Compensation Corporation. Appendix 2 traces the historical development of *Aiming for Excellence*.

This latest version of *Aiming for Excellence* draws on analysis of stakeholder groups' qualitative and quantitative feedback on the 2006 version of the instrument. The College received this feedback during the formal consultation process that it set up and managed from November 2006 to February 2007. The feedback relates to the framework of the five sections that have continued, in *Aiming for Excellence*, to define RNZCGP expectations for accessible, safe and effective general practice care in New Zealand; to the indicator groups in these sections; and to individual indicators and criteria.

As academic advisor to the RNZCGP for the development and validation of an updated version of *Aiming for Excellence*, Dr. Stephen Buetow used this feedback to help redraft *Aiming for Excellence* into a form that is responsive to the changing needs of the New Zealand health environment and learns from previous editions of this instrument. He also based his recommendations on international evidence of best practice; his experience as a general practice researcher, with independence from the College; his own informal consultation with a range of experts on individual standards; and advice provided both by an RNZCGP expert group (See p.2) The College then reworked this draft into its current form. It introduced significant revisions, added 'Further information' to the instrument and produced a comprehensive guide to aid its interpretation.

Good standards should be SMART: Specific, Measurable, Achievable, Related to their purpose and Theoretically sound. Increased attention to these attributes characterises this latest version of *Aiming for Excellence*. The College has decided that key attributes such as specificity should also characterise the guidance for interpreting the standards.

The new instrument has also been designed to reflect the context and foci of the CORNERSTONE General Practice Accreditation Programme, as depicted in Figure 1. Patients and families are at the centre. *Aiming for Excellence* has always put patients first. However, the College also understands the need for practice teams to focus on their relationships with individual patients in the context of patients' families or whānau. This allows for different levels of family involvement in these relationships [26 27] and helps to resolve uncertainty over what a focus on 'family' care entails [28]. The figure situates patients and families in three overlapping systems. The first is the practice team, which includes clinical professionals, practice management and administration, and in addition, patients as co-producers and consumers of general practice care. The second is the enrolled population to whom the practice team has responsibilities, under the Primary Health Care Strategy, to deliver individual and population-based health care, and the environments in which this team operates. The third is the health services and other sectors with which broad collaboration is needed in order to be responsive to people's diverse needs and reduce health inequalities as a key quality objective. *Aiming for Excellence* also covers what can be considered three summary dimensions of quality: accessibility, safety and effectiveness [29]. Other domains of quality, such as cultural competency, can be subsumed within these dimensions.

In support of demonstrating effectiveness, the new standards emphasise performance as well as competence, and intermediate outcomes as well as processes (how the results were achieved) and structures. Intermediate outcomes are results that can directly influence the desired end outcome, and so are as close as it is feasible to get to the end of the causal pathway [30]. Nevertheless, some processes are still specified, for example to give confidence that achievements will be maintained or bettered and because the intermediate outcomes of some indicators cannot always be easily measured.

An impressive feature of the College's CORNERSTONE programme is that it incorporates a formative ethos of organisational development at all stages. The process of assessment helps in practical terms to dissolve or at least weaken the distinction between quality assurance (to reach and maintain an acceptable standard of care) and quality improvement (what is good can be made better) in the implementation of standards. For example, practice teams can work with external assessors from the self-assessment stage to prevent problems during the assessment visit and support a shared commitment to good performance.

Consequently, quality assurance for practice accreditation has not in reality contradicted the non-punitive ethos of continuous quality improvement in the assessment of standards. However, the ongoing development of these *standards* themselves in *Aiming for Excellence* has been based on the need for summative assessment and formative assessment. Summative assessment is needed to assure the community at large that assessed practice organisations have met all the minimum quality and safety standards that are mandatory for practice accreditation. The language used to express the summative standards is the language of compliance with essential standards. In contrast, formative assessment focuses on the progress that practices have made towards meeting desirable standards through quality improvement, and gives direction to future change. Most often, quality improvement requires a commitment to continuous, small, incremental improvements in service delivery. As part of the normal daily activity of practice teams, these are the improvements that can best meet the needs of stakeholder groups in general practice care. However, when an urgent need arises for substantial learning, innovation or change by practice teams (e.g. to quickly fix systems that compromise safety), it can instead be necessary to re-engineer core processes in the practice organisation for quantum gains in quality.

**Figure 1. The context of *Aiming for Excellence***

