Dr Zena Burgess PhD
Chief Executive Officer
The Royal Australian College of General Practitioners
RACGP House
100 Wellington Parade
EAST MELBOURNE VIC 3002

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Dear Dr Burgess,

**Draft RACGP *Standards for after-hours services***

The AMA welcomes the opportunity to provide input into the RACGP's draft *Standards for after-hours services* (the Standards), which we see as a positive development.

The provision of after-hours GP services is an essential part of the Australian health system. However, poor models of after-hours GP care can lead to the fragmentation of patient care, potentially resulting in poorer health outcomes for patients. It can also impact negatively on the economic side of the health system. Services that provide after-hours GP care need to adhere to clear guidelines that complement the care provided by a patient's usual GP or regular general practice.

While there are times that an after-hours visit to a clinic or a home visit are necessary, the AMA maintains that patients should be encouraged to check the availability of their usual GP after hours and/or the arrangements their usual general practice has in place for after-hours care and to visit their usual GP in-hours if their condition is not urgent. A patient's usual GP is best placed to provide comprehensive, quality care and understands a patient's history and unique health care needs. It is important that this principle is kept in mind throughout the Standards.

The AMA's Council of General Practice (AMACGP) has reviewed the RACGP Standards and provides the following comments:

**General comments**

The AMACGP has noted the similarity of the Standards with the Standards for general practices. While the AMA can appreciate that the principles for the Standards in the Core Module should be consistent across all practices, Standards for After Hours need to reflect the specific context. An example of where the proposed standards do not reflect the context is in the Health promotion and preventive care section in Module 1. Preventative care is critically important for a patient's regular GP, and often of little or no relevance in the urgent care after-hours situation.

Offering preventative care information without knowing the patient, having access to their clinical file and little idea of what has occurred with their regular GP has the potential to cause confusion and do more harm than good. Some opportunistic advice can be appropriate, but the context is wholly different to the usual GP. This section (and the remainder of the Standards) needs to keep the after-hours context in mind.

Throughout the document there are sections which do not seem to be specifically geared towards after-hours care. Indeed, in the medical records section there is mention of 'each active patient' (p. 84) and 'lifestyle risk factors' (p. 84) which seem odd when a patient is likely not going to use the after-hours service on a regular basis. Similarly, the language 'collecting information over time' (p.868), stressing the importance of a complete health summary (p. 60) and an emphasis on collecting patient health records (p. 106-7) are not wholly suitable in an after-hours document.

There is some concern that the Standards encourage routine care through the indicators. Encouraging routine care in after-hours services facilitates the fragmentation of care and undermines patient health care. The Standards need to be very clear that for the most part routine care is the domain of the usual GP and not that of an after-hours service provider.

Generally the examples used in the Standards are reflective of normal hours general practice. It would be better to have specific after-hours examples to make the Standards an independent document with differentiation from normal hours.

Overall, more emphasis should be placed on these Standards only applying to after-hours services being provided by another entity where the usual GP is not available. After-hours visits should be not be regular and are a means of providing care until the usual GP is available. When an after-hours visit has been made follow up should be by referral back to the usual GP. The after-hours doctor should inform the patient of the need for any non-urgent tests to be discussed and arranged by visiting their usual GP in-hours. If any urgent tests are required after-hours (that cannot wait until in-hours) it is likely that the patient's condition warrants presentation to a hospital emergency department for assessment. Further, if tests are ordered with the usual GP that would require any follow-up be completed by them rather than an after-hours doctor.

**Introduction**

The definition of after-hours service specifies those services that only operate within the after-hours period as defined by Medicare. The AMA would like clarification on whether this definition is intended to cover practices who only provide services throughout the entire after-hours period as defined by Medicare, or who only provide services for part of that period e.g. from 6pm to 11pm.

It is important that the Standards either cover all scenarios or are extremely clear as to which after-hours services the standards will apply. For example, a 24 hour clinic can provide both routine care in both the normal and the after-hours period for its own patients but also cover the care of other general practices' patients in the after-hours period.

**Module 1: Core Module**

The AMA believes that the indicator for Standard 1: Communication and patient participation regarding consulting hours could create some confusion. The AMA acknowledges that both daytime and after-hours services must be assessed against the criterion and indicators of the Core Module, and that a common sense approach should be taken when interpreting these standards. However, it may be confusing if exactly the same indicators are used for after-hours services as daytime practices and would suggest that they be modified so as to be specific for after-hours services.

For example, under Criterion C.1.1 the 2nd dot point under Indicator A says 'our consulting hours and details of arrangements for care outside of normal opening hours.' This is then followed with advice on how you could meet the indicator which suggests providing brochures in other languages to explain a) available services and then b) after-hours services. The overall impression of this information is that after-hours services have after-hours.

On p.16-17 regarding *Online appointments* the Standards outlines that many practices offer online appointments for routine, non-urgent appointments. The AMA has concerns about this language, as after-hours services should not be providing routine care.

*Criterion C5.3 – Clinical handover*

The AMA would expect the information supporting this criterion to be specific to after-hours services. As defined on page 4 after-hours services are non-routine, therefore it is incongruous that an after-hours service would be providing referrals to allied health providers or uploading Shared Health Summaries. The AMA would expect that an after-hours service should be taking steps to identify a patient's regular GP and to provide a report to that GP of the care provided to their patient during the after-hours period. This sort of information is what should be included to support practices to meet this criterion.

*Criterion C8.1 – Education and training of non-clinical staff*

The AMA would expect that Indicator B would only be relevant for after-hours services with a physical clinic. If after-hours services who don't operate out of a physical clinic would be exempt from this indicator, this should be clearly stated under 'meeting this criterion'.

**Module 2:**

The AMA supports the Standards covered under Module 2 for after-hours services.

**Module 3:**

Standard 1: Providing patient care in the after-hours period

The preamble to this module outlines that there are criterion in the module that relate to a service for recalls and reminders. However, this does not correlate with the criterion presented under this Standard and is more fundamentally aligned with the principles of

routine care. The AMA suggests it would be more appropriate for the final dot point in the preamble on p.118 to say 'the system the service has for follow-up of tests and results.'

*Criterion AHS 1.1 – Arrangements with practices*

This criterion infers that an after-hours service will have a formal arrangement in place to provide services in the after-hours period on behalf of nominated practices. However, it would be easy enough for an after-hours service to have an arrangement with a few practices in order to meet this criterion but be actively providing services to patients of practices they do not have an arrangement with.

At a minimum, where a formal arrangement does not exist, as part of their triaging an after-hours service should be required to check what arrangement the patients' usual GP or practice has in place for after-hour care and direct the patient accordingly. Consideration should be given to this situation, including an indicator that covers this.

*Criterion AHS 1.4 – Home and other visits*

The AMA suggests this section needs some amendment regarding 'other health professionals' as it currently creates a capacity for after-hours services to employ 'other health professionals' rather than qualified medical practitioners to provide home visits in the after-hours period. While the AMA acknowledges in certain circumstances there may be a place for this, the College needs to be careful that it does not 'green light' models of after-hours care that could compromise the quality of care available to patients in the after-hours period. To ensure clarity in meeting this Criterion, the AMA believes that clear guidance, with the use of appropriate examples, may be required as to when it would be clinically acceptable for a non-medical practitioner member of the clinical team to attend a home visit.

When a home visit is triaged as appropriate, there needs to be some guarantee that the home visit will occur within a realistic timeframe and the patient kept appraised of any unexpected delays so that the patient can determine if they need to make alternative arrangements.

The AMA suggests more thought needs to be given to ensuring that after-hours services have processes and mechanisms in place to protect doctors when out on house calls.

*Criterion AHS 1.6 – Follow up systems*

There was some concern that the indicators under this Criterion are not strong enough to ensure adequate clinical handover, including the transfer of responsibility for the follow up of clinically significant results, from the after-hours doctor to the patient's usual GP. There is a need to ensure a process is in place that clearly signals who will be responsible for the follow up.

For example if it is the patient's GP, the handover should ensure the GP is provided with the results and clearly told that the patient has been asked to follow up with them and that the after-hours service will not be doing so. If the patient does not have a usual GP then there should be an indicator to ensure the patient is advised within an appropriate time of any

clinically significant results and directed to an appropriate care provider. The AMA does not want to see patients slipping through the cracks and it is important that the standards adequately address this.

*Criterion AHS 2.1 – Qualifications, education and training of healthcare practitioners*

The AMA acknowledges the stipulation under Indicator B that where non-GP medical practitioners are employed the service can demonstrate they are supervised and have the training necessary to meet patient needs.

*Criterion AHS 3.2 – Service Equipment*

There was some contention around the exclusion of the vaginal specula from the doctor's bag. We can understand that it may have been excluded as it would be more relevant for routine care but perhaps consideration should be given to its discretionary inclusion. Examples were provided of situations where its inclusion may be appropriate such as for assessment of bleeding in pregnancy, cervical shock, or non-rape trauma.

We note that, in the context of the current review of MBS after-hours funding arrangements, there is the potential for significant reforms to after-hours arrangements including specific measures targeted at improving the quality of medical deputising services. In this regard, the further development of these standards will need to take into account the outcomes of this review – as well as the comments provided in this consultation process.

Yours sincerely

Dr Richard Kidd
**Chair, AMA Council of General Practice**