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**AMA Submission in response to the Second Draft if the RACGP Standards for General Practices (5th edition)**

Thank you for inviting the AMA to comment on the Second Draft of the -RACGP Standards for General Practices (5th edition). The AMA is pleased to see that our previous comments and suggested amendments on the first draft have been considered and for the most part been incorporated into this latest version. The AMA welcomes the opportunity to work with the College in the development of the next edition of the Standards to ensure that the Standards are practical, achievable and provide direction for Australia's general practices in the provision of safe and quality care.

**General Comments**

The AMA welcomes the College's move to make the presentation of the Standards consistent across the document. This provides greater clarity for practices as to what is required, why it is important and the processes by which they can demonstrate they have met the Criterion.

**Introduction**

The AMA believes it would be useful if there was a sentence in the introduction advising practices of the availability of the Resources document, along with the web address and link for where to find it.

**Module 1: Core Module**

The AMA supports the re-ordering of the Standards 1-3 in the Core module. This is a sensible and logical approach given general practice provides an effective first point of contact for patients, and communication with patients is the fundamental element of providing quality patient-centred care.

**Criterion C1.2 – Telephone and electronic communications**

As the notes indicate "Meeting this Criterion" that practices can choose to communicate with patient using electronic means the "Indicator" which is currently an absolute statement

should be amended to reflect this. The AMA would recommend amending the indicator to read as follows (amendments in blue):

> Our practice manages telephone calls, telephone messages and/or electronic messages from patients.

There is a grammatical inconsistency between the first paragraph under *Communicating by electronic means* and the following dot points. To rectify this it is suggested that the words "while also" be replaced with "and".

**Criterion C1.5 – Costs associated with care initiated by the practice**

The AMA believes that the amendments to the notes under "Meeting this Criterion" does provide greater clarity about what can reasonably be expected of the practice in advising patients about the costs of care.

**Criterion C2.1 – Respectful and culturally appropriate care**

The AMA supports the intent of the third paragraph under *Respectful and culturally appropriate care* regarding patients being advised why they are being asked to identify their ATSI status or cultural background. However, the AMA has concerns that this paragraph wrongly infers by its use of the Aboriginal or Torres Strait Islander status example that an indication of Aboriginal or Torres Strait Islander status is an indication of a cultural belief. To remedy this the AMA would suggest removing or modifying the example.

Under "Demonstrating how you meet this Criterion" the AMA is unclear as to how "Provide a transport service patients who are otherwise unable to travel to the practice" would be a way to meet the requirement of C2.1A. This is more relevant to access issues and thus more appropriately listed under C2.3.

**Criterion C2.2 – Presence of a third party during a consultation**

The AMA notes the revision of the indicator for this criterion, agreeing it is a more logical and practical position that if the patient arrives with a third party that consent for their presence is implied.

**Criterion C2.3 1 – Access to services**

Under "Meeting this Criterion" and *Access is important* the AMA suggests including an additional paragraph to advise that in some circumstances practices may choose to provide a transport service for patients who are otherwise unable to travel to the practice. This would then better correlate with the ways listed for demonstrating how the practice meets the indicator for this criterion.

**Criterion C3.1 – Business operation systems**

In response to the Stakeholder question, the AMA notes the change in terminology from "business risk management" to "business operation systems" takes a more comprehensive approach to how practices can maintain and improve the quality of care through good governance and management. It facilitates a focus on good business practice, continual improvement and creating an environment that enables it, and risk management. In an environment where practice viability seems to be continuously under threat the AMA believes sound business practice is a fundamental aspect of running a general practice.

The AMA notes that indicator B for this criterion has been downgraded from mandatory (as proposed in the first draft) to aspirational. The AMA believes practices should voluntarily embrace the concepts of continuous improvement and in so doing evaluate their progress towards their goals, but notes that not all practices may be currently be equipped to do so, and is therefore comfortable with the indicator being an aspirational one.

**Criterion C5.2 – Clinical autonomy for practitioners**

The amendment to this indicator is an acknowledgement that many practices are now comprised of a multidisciplinary team. The AMA believes it is important that the notes under the criterion emphasise that clinical autonomy must be exercised within the practitioner's scope of practice. To this end the AMA would suggest amending the second paragraph to read as follows (amendments in blue):

> The intent of this Criterion is that, instead of having decisions imposed on them the practitioner is free (within their scope of practice) to provide the best level of care for each individual patient, based on their clinical judgement and current clinical and other guidelines.

Under "demonstrating how you meet this criterion", the AMA would also like to see some further elaboration of how a practice might provide evidence that practitioners adhere to their own professional obligations and code of ethics.

**Criterion C6.1 – Requesting a preferred practitioner**

The AMA believes that patients should be able to see their preferred practitioner, where ever possible.

Under "Meeting this Criterion" the sentence advising that the practice "could" inform the patient when they can't see their preferred practitioner is not strong enough. The AMA suggests the following instead:

> On an occasion where a patient's preference is unable to be met the practice informs the patient and explains why.

**Criterion C9.1 – Qualifications and training of healthcare practitioners**

The AMA notes and supports the qualification for Indicator B that the clinical team is trained to use the practice's equipment, relevant to their role.

The AMA is however concerned that the notes under "Why this is important" suggest that all healthcare practitioners must have undertaken Aboriginal and Torres Strait Island cultural awareness training. While the AMA acknowledges the benefits of this training and that it is requirement for practices participating in the Federal Government's Practice Incentive Payment Indigenous Health Incentive (PIP IHI), the notes should not be suggesting that this is a mandatory requirement for all healthcare practitioners as it is not listed in Indicator A as a requirement, and potentially imposes an unnecessary burden on those practitioners who already have extensive experience working with Aboriginal and Torres Strait Islander peoples. The AMA notes that the RACGP's Introduction to Aboriginal and Torres Strait Islander Cultural Awareness Active Learning Module is no longer free to non-members of the College. The AMA believes the College has a conflict of interest in making it appear in the notes that this is a

requirement. The AMA would suggest that this dot point should be modified to read as follows (amendments in blue):

- where appropriate, have undertaken Aboriginal and Torres Strait Islander cultural awareness training.

The notes under *Practice equipment*, are not clear due to some typographical errors. The AMA suggest the intent of this paragraph could be better clarified if it read as follows (amendments in blue):

> Training requirements depend on the piece of practice equipment and the relevance of the equipment to the role of the clinical team. Clinical staff must be trained on how to use practice equipment safely to avoid any adverse events. An assessment could be undertaken as to whether specific training is required for practice equipment, such as the height-adjustable bed, Point of Care Testing equipment or the defibrillator (if the practice has one), and to determine whether ongoing training is required. Practice equipment training can be undertaken through external courses or 'on the job' training at the practice.

**Criterion C9.2 – Qualifications and training of non-clinical staff**

The AMA notes the relaxation of the requirement under Indicator B compared to C3.2.3 from the 4th edition, in that non-clinical staff will now only need to be offered CPR training at least every three years rather than having to undertake it. This relaxation is more appropriate with regard to the role of non-clinical staff.

**Module 2: Quality Improvement Module**

**Criterion QI1.2 – Patient feedback**

The AMA welcomes the streamlining of the indicators for this criterion and notes the action rather than process focus. The AMA notes that as well as having to demonstrate to accreditors how the practice has responded to patient feedback for the purposes of quality improvement, that the practice will now also be required to share this with patients. The AMA agrees that promoting to patients how the practice has used their feedback for quality improvement is an important element in strengthening the relationship between the practice and the patient by affirming the value of patient feedback and how it contributes to the practice's quality improvements. It enhances the concept of patient-centred care and that the patient is part of the team.

**Criterion QI2.1 – Health summaries**

The notes now clearly advise practices how they can demonstrate they have met the indicators for this criterion. In meeting the requirements of the criterion practices will improve the quality of their patient records and become more accustomed to auditing their records which will enhance their capacity for quality improvement activities.

**Criterion QI2.2 – Safe and quality use of medicines**

The reordering of the content under "Why this is important" provides an improved flow of information.

The AMA appreciates the acknowledgement of the role that pharmacists can play in facilitating the optimal use of medicines and how a good partnership between the GP, patient and pharmacist can enhance medication management.

The AMA supports the inclusion in the notes of the sentence highlighting the need to ask patients about any complementary medicines given it will assist in meeting the requirements under Indicator A and in minimising the potential for adverse outcomes.

**Criterion QI3.2 – Open disclosure**

The AMA agrees that this criterion is more appropriately placed as a criterion for 'Clinical risk management' than for 'Practice governance and management', particularly as it provides the opportunity for the acknowledgment of mistakes and subsequent learnings which can only serve to enhance the safety and quality of patient going forward.

**Module 3: General Practice module**

**Criterion GP1.1 – Responsive system for patient care**

The AMA believes that the mandatory requirement regarding prioritising patients listed under "Demonstrating how you meet this Criterion" for GP1.1A has been incorrectly placed and would be better located under GP1.1B given this indicator is related to triage.

Given that varied business models under which general practices operate the AMA notes that not all practices may have an appointment system in the strictest sense. Such practices could demonstrate they have met GP1.1.A by maintaining a register of appointments that shows the practice does provide a variety of consultation types. The AMA therefore suggests that under "Demonstrating how you meet this Criterion" for GP1.1A the words "or register of appointments" be included after "Keep an appointment system".

**Criterion GP1.2 – Home and other visits**

The AMA notes the amendments under *Defining 'safe and reasonable' in the local context*, which elaborate on the meaning of safe and reasonable and how that is to be interpreted and assessed under the Standards with regard to providing patients with care outside of the practice.

**Criterion GP1.3 – Care outside normal opening hours**

In general there has been an increased focus in the notes around practices providing their own after hours care (or as part of a cooperative) which the AMA approves of. To ensure there is two-way communication between the practice and the after-hours provider and continuity of care the AMA suggests the following sentences are included at the end of the content under *After –hours care*:

> Your practice could also make provision with the after-hours provider that the day-time contact details for the attending practitioner be provided with the patient report should a member of the clinical team have any follow-up queries.
>
> To assist any after-hours provider providing services on your behalf your practice could also provide them a list of patients likely to need their care in the after-hours period with relevant factors for provision of their care such as for palliative patients.

Under “Demonstrating how you meet this Criterion” for GP1.3A, the AMA notes and disagrees with the removal of the following sub dot point which appear in the first draft:

- Ensure this message explains that out-of-hours care is only available for medical situations that cannot wait for a consultation during normal opening hours.

The AMA believes this an important message to share with patients to ensure appropriate use of after-hours services and would like to see this point reinstated.

**Criterion GP1.5 – Follow up systems**

Under “Demonstrating how you meet this Criterion”, the AMA believes that documenting the patient’s agreement to have the tests recommended for them is superfluous to the GP1.5A. The focus of this indicator is on the practice reviewing, recording and acting on results received by the practice. The AMA suggests removing this from the table.

**Typographical errors**

There are a number of typographical errors that our team at the AMA have picked up. Rather than go through these in this response I suggest that your team contact Michelle Grybaitis, Senior Policy Adviser on 02 6270 5496 to go through them.

Yours sincerely

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Chair
AMA Council of General Practice