17/75

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Dear Dr Burgess,

Revised Draft RACGP *Standards for after-hours services*

The AMA welcomes the opportunity to provide further input to the RACGP's draft *Standards for after-hours services*. The AMA is pleased to see that some of our suggestions regarding the previous draft of the *Standards for after-hours services* have been taken on board and incorporated into this revised version. We acknowledge the work the College has done to improve the relevancy of these standards. Nevertheless, the AMA still has some concerns that for the sake of clarity and applicability should be addressed.

The AMA's Council of General Practice (AMACGP) has reviewed the RACGP's draft *Standards for after-hours services* and informed this response.

Definition of after-hours or medical deputising service for the purposes of accreditation

The AMA appreciates that the RACGP has made some amendments to the definition of an after-hours or medical deputising service following our request for greater definitional clarification. However, the AMA suggests that further amendments are required as the current definition still generates confusion about which service providers these standards are applicable to.

The first dot point of the definition creates this confusion because it seems to be either suggesting that a medical deputising service that operates 24/7 (along with Medicare) can define the after-hours period **or**, that in order to be a medical deputising service accredited against these standards the service must be a medical deputising service which operates 24/7. While medical deputising service phones may be manned 24/7 most only provide services in the after-hours period as defined by Medicare.

For the purposes of greater clarity the AMA would suggest that the criteria which must be met by a service seeking accreditation under these Standards are:

- be an after-hours service that accepts appointments and provides patient care only within and for the whole after-hours period as defined by Medicare OR
- be a Medical Deputising Service that operates 24/7 and when providing after-hours services does so only within and for the whole after-period as defined by Medicare

- provides after-hours attendances that are predominantly single episodes of non-continuing care, non-routine and predominantly of a general practice nature
- except where specifically exempted, meet all the mandatory indicators in the Core, Quality improvement, and After-hours services module.

Module 1: Core Module

Standard 1: Communication and patient participation

We note and support the contextual changes made to this Standard and its Indicators as they are now more appropriate and relevant to the operation of an after-hours service provider or medical deputising service.

Standard 3: Service governance and management

Criterion 3.3 – Emergency response plan

Under 'Meeting each indicator' the second dot point needs to replace the word "place" with "plan" so it reads:

- create a position description for a team member responsible for maintaining the emergency response plan.

We note the swapping of the above from being a 'could' action to a 'must' action with 'educating the whole team about the emergency response plan'. We agree that this is a more appropriate action for meeting the indicator of 3.3.

Criterion 3.4 – Service communication and teamwork

The AMA notes the amendments made under 'Meeting each indicator' for C3.4.A and C.3.4.C as these are more appropriate actions for demonstrating the indicator has been met.

Criterion 3.5 – Work health and safety

Under "Safety of your service team' the examples given mostly relate to a service with physical premises. Consideration should be given to more examples to reflect the health and safety issues that staff attending house calls, which is the predominant method of service delivery in the after-hours industry, may face. For example, ensuring road side assistance is available for all practitioners undertaking home visits, and ensuring the practitioner can directly alert the call centre in the case of an accident, breakdown, etc.

The paragraph beginning 'Where there is a service operating…' the words 'from a physical premises' need to be inserted after 'operating' to emphasise where references to desks and workspaces, etc are relevant.

Indicator C3.5.B is over-prescriptive and inconsistent with this indicator in the *Standards for General Practices* (5th edition) and the last paragraph in these standards under 'Why this is important', which states 'services are to encourage members of the service team to be immunised'. Encouraging team members to be immunised is very different to making it mandatory that they are. Individuals have the right to decline a vaccination. The service entity must then manage how members of the service team who decline to be vaccinated or to have their immunisation status tested are best utilised.

Also what is meant by 'our service team'? Does it mean the whole team or most of them? If most team members are immunised but some are not does that preclude the service from meeting that indicator. What threshold is the College proposing for team immunisation?

Where a practitioner does not consent to a) a vaccination or b) the recording of their immunisation status, what is required of the practice in terms of meeting this indicator? The AMA has previously been advised by an accrediting agency that if the denial of consent is documented the practice would not be precluded from meeting the indicator. The AMA suggest that an additional sentence be included under "Why is this important" that says:

> Should a member of the service team decline the offer of a vaccination or deny consent to the recording of their immunisation status the practice should document this.

The AMA would support the use of an indicator like that which applies to general practices as follows:

> C3.5.B Our service team is encouraged to obtain immunisations recommended by the current edition of the *Australian Immunisation Handbook* based on their duties and immunisation status.

If the C3.5.B is not amended as suggested you may need to include another dot point under 'How to meet this indicator' under 'You must' to indicate that the practice must record where a team member declines the offer of a vaccination or does not consent to their immunisation status being recorded.

Standard 4: Health promotion and preventive activities

The AMA notes and supports the removal of the paragraphs in the introduction to this standard on the role of general practice in preventive activities. The AMA also acknowledges the rewrite of the text under 'Meeting this Criterion' and 'Meeting each Indicator' which recognises the opportunistic and ad-hoc nature of these activities in an after-hours or medical deputising environment.

However, the AMA really questions the relevance of this Standard in its entirety in the context of after-hours and medical deputising services. We suggest it is completely rewritten to better reflect the contextual environment. The introduction, for example, currently refers to 'in education clinics'. Under no circumstances, would or should an after-hours or medical deputising service be providing 'education clinics' for patients.

Our day time GPs see health promotion and preventive care as a fundamental element of routine care and not something that a practitioner providing non-routine and single episodic care would be providing. Nevertheless, there is a role for after-hours doctors to support the patient in taking an interest in their health with the provision of health promotion or preventive care information, should an appropriate opportunity arise. However, to facilitate continuity of care after hours doctors should recommend patients follow-up with their usual doctor.

It is also very unclear how an accrediting assessor would determine if a practice met Indicator C4.1. For example, if an appropriate opportunity to provide health promotion or preventive activities never arises then the service will not have any discussions documented in the patient record. With no discussions documented how does the service prove it has met the criterion?

Standard 5: Clinical Management of health issues

The AMA notes the minor amendments to align the content of this standard to the context, particularly given our previous comment regarding Criterion C5.3 – Clinical handover. We appreciate the changes specifically made to this criterion that reflect the circumstances where crossover of care occurs and the handover of care back to the patient's regular GP.

Standard 6: Information management

The AMA notes the amendments to Criterion C6.1 and supports the emphasis on the importance of this criterion.

The AMA notes the improved relevancy of the supporting information across the whole Standard.

Standard 7: Content of patient health records

The AMA notes the removal or amendment of indicators to ensure their relevance to an after-hours or medical deputising service, and the use of more constructive actions for meeting the indicators. The removal of the indicator regarding the follow-up of problems raised in the previous consultation, for example, is welcomed along with the removal of the section on collecting patient information over time as these are tasks more relevant to the patient's usual GP.

Standard 8: Education and training of the service team

The AMA acknowledges the change to C8.1.B reflecting that it is only the non-clinical staff who have direct contact with patients who would require CPR training, as per our previous submission. The AMA also appreciates the inclusion of training in after-hours triage under 'Meeting this Criterion'.

<u>Module 2: Quality Improvement module</u>

The AMA notes the changes to ensure contextual relevance and continues to support the Standards covered under Module 2 for after-hours or medical deputising services.

Standard 2: Clinical indicators

Criterion QI2.1 – Health summaries

The AMA notes the intention of this criterion is that only those patients who have utilised the after-hours service or medical deputising service three times in the last two years would have a health summary. However, we think this needs to be made more explicit other than via the single use of the term 'active patient' when advising services how to meet the criterion.

There is an inconsistency in the wording of QI2.1.B on page 105 to how it appears on page 106 under 'Meeting each Indicator' which needs to be rectified. The latter version has the additional words 'where relevant' and it would be more appropriate these words were also included in the Indicator on page 105. The Indicator as it currently appears on page 105 reads as if the health summary must be inclusive of all the information listed in the dot points. Items that are more the domain of the patient's usual GP, such as immunisations for example, should not appear as mandatory information to be collected by an after-hours or medical deputising service. The AMA notes that in the *Standards for General Practices* (5th edition) this indicator does include the words 'where relevant'.

Furthermore, mention should be given to where formalised deputising arrangements exist the service should have access to the health summaries of the usual practice.

Also, the supporting text refers to health summaries being important to assist medical students (among others) in obtaining an overview of the patient's care. It is our understanding that medical students are not typically placed in a medical deputising or after-hours service, and so we query the inclusion of this reference, as it seems more relevant to a day time general practice.

Criterion QI2.2 – Safe and quality use of medicines

The AMA notes the contextual relevance of the reduced set of indicators selected for this criterion and the supporting text.

Module 3: After-hours and medical deputising services module

The AMA notes that for the most part changes have been made to this module in line with those suggested in our previous submission. However, where there is no formal arrangement in place with the patient's usual GP/practice the after-hours or medical deputising service should be required as part of their triage process to check the after-hours availability of the patient's usual GP/practice before either making the appointment or referring the patient to their usual GP/practice if they are available.

Standard 1 Providing patient care in the after-hours period

Criterion AHS1.2 – Responsive system for patient care

The AMA believes the supporting text under this criterion regarding triage needs to be strengthened to further emphasise that routine or non-urgent care should be provided by the patient's usual GP. To that end under 'Triage' we suggest amending the second and final sentences so they read as follows:

> The staff who are triaging the call must be able to determine the needs of the patient and schedule an appropriate consultation according to the urgency of the situation, or refer the patient either to their usual GP or to an emergency department as required.
>
> For non-urgent issues or requests for appointment for routine care, the service needs to advise the patient to call their regular GP during normal business hours.

In addition, this criterion could benefit from including a sentence such as:

> The service should check with the patient's usual practice and where it is providing extended hours care, or its practitioners are accessible (ie on call) in the after-hours period, the patient should be directed to them in the first instance.

Criterion AHS1.3 – Safety of the service team

There is inconsistency under 'Meeting this Criterion' in the use of the WH&S and OH&S. Given the governing legislation is the Work Health and Safety Act 2011, the AMA suggests consistent use of WH&S.

The additional dot point under 'Reducing risk to service staff' about keeping drugs of dependence in the car unless needed, is noted and seems appropriate.

Criterion AHS1.4 – Home and other visits

The AMA remains concerned at the implications of this section regarding the use of 'other health professionals', as per our previous submission. Our members are highly aware of the risks of 'task-substitution' and business models that could emerge if these standards are seen to 'green light' the use of other health professionals over a medical practitioner. To alleviate this concern the AMA suggests that under 'Who can perform home or other visits?' the second sentence be replaced with the following:

> In most situations, a medical practitioner is required but sometimes, another member of the team, such as a nurse working within their scope of practice may be able to perform the required duties.

This does not preclude the use of 'other health professionals' where appropriate but reinforces the expectation that patients would be seen by a medical practitioner. It also provides accreditation assessors with a better boundary of what is and isn't acceptable.

Criterion AHS1.6 – Follow up systems

The AMA appreciates the changes made to this Criterion, in line with our previous submission, which make it clearer when the after-hours practitioner is responsible for following up on test results and to ensure adequate clinical handover.

Standard 2: Qualifications of our clinical team

No comment required.

Standard 3: The after-hours service facilities

No comment required.

Yours sincerely

Dr Richard Kidd
Chair, AMA Council of General Practice