

# Framework for Victorian co-located after-hours general practice clinics

2009



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## Executive summary

Victoria's co-located after-hours general practice (AHGP) clinics are special-purpose services located within a public hospital, near or adjacent to its emergency department (ED). The clinics provide acute, episodic primary care services on a walk-in basis and operate outside business hours on evenings, weekends and public holidays. The clinics provide an alternative to treatment in a hospital ED and are designed to support the provision of emergency primary medical care in the community.

The *Framework for the Victorian co-located after-hours general practice clinics* has been developed by the Department of Health (the department) as a resource for health services, general practices and general practice divisions (GP divisions) engaged in providing co-located AHGP clinics. It provides an overall structure for establishing and operating co-located AHGP clinics and is intended to promote consistency of practice and support continued service improvement.

The framework sets the context for co-located AHGP clinics by charting the development of this model of care, describing the service system in which it operates and relevant state and national policies. It delineates the role and supporting principles of the service, addresses the collaborative relationships underpinning service provision and outlines the criteria for establishing new clinics.

The role of co-located AHGP clinics is to provide timely, safe and accessible services for consumers seeking primary medical care outside business hours. In particular, the clinics have a role in:

- ensuring care is provided in the most appropriate setting
- minimising hospital utilisation and optimising ED care for more acute presentations
- managing unmet demand in the community for emergency primary medical care
- complementing and supporting primary medical care services in the community
- supporting the general practitioner (GP) workforce
- promoting sustainable collaboration and partnerships between health services and general practice
- improving the quality of health care
- optimising resource use and efficiency of care across multiple providers.

The framework provides guidance to collaborative partnerships of health services, general practices, GP divisions and local general practices proposing to establish a new co-located AHGP clinic by outlining the:

- joint and separate responsibilities for various components of the service and the ongoing viability and sustainability of the clinics
- criteria and approval processes for establishing new services
- processes for engaging well-located AHGP clinics.

The framework describes the key aspects of service delivery for a co-located AHGP clinic including scope of practice, access and continuity of care. The individual and shared responsibilities of health services and general practices in delivering this model of care are a major focus of service delivery. Key areas addressed include:

- scope of services provided
- physical facilities

- access to services through signage, consumer information and screening criteria
- continuity of care through notifications and information exchange between services.

The framework outlines the governance, management and organisational structures supporting co-located AHGP clinics. These arrangements are designed to support collaborative partnerships and accommodate different approaches to the ownership, governance and business models employed in AHGP services. Key areas addressed include:

- the Medicare program, funding and billing practices
- corporate governance
- practice management and administration
- clinical governance
- staffing
- performance monitoring.

The clinical governance of collaborative partnerships is a key component of the co-located AHGP clinic framework. The clinical governance framework is designed to ensure continuous improvement in the safety and quality of care and covers six domains:

- governance structures
- purposes, roles and responsibilities
- systems to deliver quality clinical care
- provider competence and performance
- data and information
- clinical risk management.

A toolkit developed by DLA Phillips Fox is provided to assist health services and general practice clinics to implement the clinical governance framework and provide high-quality care in an environment in which risk is understood and managed.

## 1.0 Introduction

The Framework for the Victorian co-located after-hours general practice clinics has been developed by the Department of Health (the department) in conjunction with the Co-located After-Hours General Practice Clinics Working Group and the Emergency Access Reference Committee (EARC) – Primary Care Subcommittee, General Practice Victoria, the Royal Australian College of General Practice and other key stakeholders. (Refer to Appendix 1 for details.)

Victoria’s co-located AHGP clinics are special-purpose services located within a public hospital, near or adjacent to its ED, which provide acute, episodic primary care services on a walk-in basis. Consumers attending the ED after hours for emergency primary medical care are informed about the practice and may elect to be treated at the clinic.

The framework is a resource for health services and general practices providing co-located AHGP clinics for consumers presenting to hospital EDs for primary medical care. It provides an overall structure for collaborative partnerships setting up and providing a general practice clinic within a public hospital environment, one that recognises that clinics are private practices with distinct business, management and administrative structures. The shared responsibilities involved in providing viable, high-quality services that place consumers at the centre of their care are a key focus of the document.

The framework provides an overall structure for establishing and operating co-located AHGP clinics and guidance on the future provision of after-hours primary medical care in Victoria. Specifically, the framework:

- defines a co-located AHGP clinic
- delineates the role and supporting principles of the service
- addresses the collaborative relationships underpinning the services
- outlines the criteria for establishing and approving new clinics
- describes the key aspects of service delivery including scope of practice, access and continuity of care
- outlines the governance, management and organisational structures supporting co-located AHGP clinics.

The framework is intended to promote consistency of practice across health services and to support continued service improvement. It is not prescriptive and allows for individual health services and general practices to develop clinics that align with their differing organisational arrangements and meet the needs of their local communities, primary medical care services and patient populations.

### 1.1 Background to Victorian co-located after-hours general practice clinics

Victoria’s public hospitals have experienced a sustained growth in demand for ED care over the past decade. Primary care type (PCT) presentations<sup>1</sup> constitute around half of all ED presentations and

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<sup>1</sup> *The Victorian Emergency Minimum Dataset (VEMD) defines PCT presentations as patients with the following characteristics: did not arrive by ambulance; were not referred by a GP; were classified as Australian Triage Scale triage category 4 or 5; were not admitted; and had a total length of stay of less than 12 hours.*



occur more frequently in the evenings and at weekends.<sup>2</sup> There is a correlation between PCT ED presentations and the accessibility of GP services.<sup>3</sup>

In late 2003 there were two co-located AHGP clinics operating in metropolitan Melbourne at Dandenong and Frankston hospitals. At this time, following discussions with the Commonwealth as part of the 2003 Australian Health Care Agreement, the then Department of Human Services proposed the development of Commonwealth–state cost shared co-located AHGP clinics<sup>4</sup> to extend this model of care and address the growing demand for PCT services in EDs.

In 2004 the Commonwealth agreed to extend the number of co-located AHGP clinics nationally with access to Medical Benefits Schedule (MBS) funding conditional upon criteria including the need for local GP and GP division support and that the clinics be operated by a separate entity to the hospital in which it is located.

In keeping with the Commonwealth's commitment to maintaining fee for service as the basis of GP funding, the co-located clinics were funded through MBS with additional grants from the Commonwealth and state governments.

In 2005–06 the Victorian Government provided additional funding over four years to support the wider implementation of new emergency models of care. The new models of care funding supported additional co-located clinics at the Northern and Royal Children's hospitals by 2006 and at the Austin Hospital and the Monash Medical Centre by early 2008.

## 1.2 Review of co-located clinics

In 2007 the department commissioned Campbell Research & Consulting to conduct a review of co-located AHGP clinics to determine the impact of co-located AHGP clinics in reducing the demand for PCT services in hospital EDs, to assess their financial viability of the services and their financial impact on hospitals and to determine the future of this model of care in Victoria.

The findings of the review<sup>5</sup> indicated co-located AHGP clinics were containing the growth in ED demand but their capacity was underutilised, with patient throughput lower than anticipated. The re-direction of consumers to co-located AHGP clinics was influenced by concerns about quality of care and the relationship between co-located AHGP clinics and the local ED and GPs.

The review found the cost of providing care in a co-located AHGP clinic was lower than the cost of providing treatment in an ED. All the co-located AHGP clinics required a government subsidy and were not financially viable when solely dependent on MBS revenue.

The departmental review contained a range of recommendations that addressed the future of this model of care in Victoria. Specifically, that co-located AHGP clinics be established according to set criteria and systematically strengthened through a service framework and effective clinical governance systems.

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*2 Department of Human Services 2009, Trends in primary care type patients presenting at Victorian metropolitan and rural emergency departments (unpublished), Melbourne.*

*3 Booz Allen Hamilton Ltd 2008, Key drivers of demand in the emergency department – A hypothesis driven approach to analyse demand and supply, Sydney.*

*4 Department of Human Services 2003, Commonwealth–state cost shared development of co-located primary care clinics, State Government of Victoria, Melbourne.*

*5 Campbell Research & Consulting 2007, Review of after-hours co-located general practice clinics, Melbourne.*

In 2008 the department established the Co-located AHGP Clinic Working Group to oversee the development of the *Framework for the Victorian co-located after-hours general practice clinics*, the mainstreaming of this model of care and the development of the companion document *Clinical governance of co-located and well-located after-hours general practice services – A framework and toolkit*.<sup>6</sup>

### 1.3 Policy context

The Framework for the Victorian co-located after-hours general practice clinics has been developed in the context of national and state policies and directions. As co-located clinics operate at the interface between hospitals and primary medical care and spans Commonwealth and state government responsibilities, a wide variety of policies and programs are relevant to co-located AHGP clinics. The relevant information is detailed in Appendix 2.

*Better faster emergency care*<sup>7</sup> is the key policy informing the co-located AHGP clinic framework. This policy outlines ten key priorities for the equitable and timely access to quality emergency care within public hospitals.

### 1.4 Service context

After-hours primary medical care is provided by a range of services including private GP practices, GP deputising services, community health centres, public and private hospital EDs and co-located AHGP clinics. The key service providers include:

- general practices offering extended hours of service
- after-hours-only GP clinics operated and staffed by a cooperative of local GPs with practice management support, which in some instances is facilitated through the local GP division
- medical deputising services that provide overnight<sup>8</sup> home visits, clinic and telephone triage and medical advice services in response to patient or GP-initiated calls
- hospital EDs that provide fast track services for the timely assessment, treatment and discharge of consumers seeking PCT services
- co-located AHGP clinics that are located within a public hospital, near or adjacent to its ED
- community health services with minor injury and illness or urgent care centres that provide episodic multidisciplinary primary health care over extended hours on a walk-in basis
- GP super clinics that provide integrated multidisciplinary team-based approaches to health care, particularly chronic disease prevention and management.<sup>9</sup>

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<sup>6</sup> DLA Phillips Fox 2009, *Clinical governance of co-located and well-located after-hours general practice services – A framework and toolkit*, Melbourne.

<sup>7</sup> Department of Human Services 2007, *Better faster emergency care*, Melbourne, State Government of Victoria, pp. 39–42.

<sup>8</sup> National Association for Medical Deputising 2007, *Definition of a medical deputising service*, NAMDS, Melbourne.

<sup>9</sup> See <<http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics>>.

## 2.0 Principles and service descriptors for co-located clinics

The following section of the framework outlines the key features of a co-located AHGP clinic, the role of the service and the supporting principles that underpin service delivery. The population serviced by the clinics is also addressed.

### 2.1 Service description

Victoria's co-located AHGP clinics are special-purpose services designed to support the provision of emergency primary medical care in the community. They represent a new model of care that provides an alternative to treatment in a hospital ED.

The key characteristics of co-located AHGP clinics are listed below.

Co-located AHGP clinics:

- provide acute, episodic primary care services on a walk-in basis
- are located within a public hospital, near or adjacent to but physically separate from the hospital ED
- only operate in the out-of-hours period including evenings, weekends and public holidays
- have the character of a community-based general practice
- are private practices with distinct business, management and administrative structures to the hospital in which they are located
- have access to MBS funding
- are staffed by GPs and staff competent in general practice management and administration
- do not provide specialist medical services<sup>10</sup>
- have a formal relationship with the hospital ED
- are supported by local GPs and divisions of general practice.

### 2.2 Supporting principles for service delivery

The core principles that underpin service delivery in co-located AHGP clinics are as follows.

#### Person- and family-centred care

Services place consumers at the centre of their care. A collaborative and respectful partnership exists between consumers and practitioners.

#### High-quality health care

Services are of a high quality and are provided in a governance structure that supports appropriate clinical care and continuous quality improvement.

#### Safe environment

The environment in which services are provided are safe for both practitioners and consumers.

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<sup>10</sup> As defined by Medicare Australia for purposes of MBS funding. Refer to Department of Health and Ageing 2007, Guidelines for the recognition of medical practitioners as specialists or consultant physicians for Medicare purposes under the Health Insurance Act 1973, Australian Government, Canberra.

**Continuity of care**

Services are coordinated and integrated across care settings and promote continuity of care for consumers.

**Cost effective and sustainable**

The model of care is viable, cost effective and sustainable in the long term.

**Accessible services**

Services are affordable and are provided in an accessible environment.

**2.3 Role of co-located after-hours general practice clinics**

The role of co-located AHGP clinics is to provide timely, safe and accessible services for consumers seeking primary medical care outside business hours.

In particular, co-located AHGP clinics have a role in:

- ensuring care is provided in the most appropriate setting
- minimising hospital utilisation and optimising ED care for more acute presentations
- managing unmet demand in the community for emergency primary medical care
- complementing and supporting primary medical care services in the community
- supporting the GP workforce
- promoting sustainable collaboration and partnerships between health services and general practice
- improving the quality of health care
- optimising resource use and efficiency of care across multiple providers.

**2.4 Population managed through co-located clinics**

The people managed through co-located AHGP clinics include consumers with acute symptoms that can be treated within the usual scope of general practice and who:

- present to an ED after hours
- are unable to access a community-based AHGP clinic or deputising service
- are advised to attend by their usual GP or another primary care provider.

The consumers targeted by individual co-located clinics will reflect the hospital's patient population and the demographic and service profile of the communities they serve.

## 3.0 Establishing new services

The following section of the framework provides guidance to health services, GP divisions and local general practices proposing to establish a new co-located AHGP clinic. It reflects the shared responsibilities of all parties involved in the process.

### 3.1 Service integration

Co-located AHGP clinics are designed to manage unmet demand for emergency primary medical care by providing an alternative to treatment in a hospital ED and to complement and support primary medical care services in the community.

As this model of care addresses the needs of both the primary care sector and the acute care sector, it requires a collaborative partnership focused on service integration. This approach is supported in the broad policy directions articulated by both state and national governments.<sup>11</sup> Integration is understood in terms of the World Health Organization's definition that states that health service integration is 'bringing together common functions within and between organizations to solve common problems, developing commitment to a shared vision and goals and using common technologies and resources to achieve these goals'.<sup>12</sup>

Service integration and the development of collaborative partnerships between health services and local GP divisions and general practices underpin the establishment of sustainable co-located AHGP clinic services.

The General Practice Liaison (GPL) program provides a structured system for developing partnerships between health services, divisions and general practice.<sup>13</sup> Health services may utilise their GPL service and their formal, established linkages with local GP divisions and general practices to form a collaborative partnership around co-located AHGP clinics.

### 3.2 Collaborative partnerships

A collaborative partnership<sup>14</sup> entails health services and their local GP divisions and general practices taking joint and separate responsibility for various components of the service and the ongoing viability and sustainability of the clinics.

Areas of interest that may be jointly considered by the health services, GP divisions and local general practitioners involved in providing an AHGP clinic are presented in the following box.

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<sup>11</sup> Refer to Appendix 2.

<sup>12</sup> World Health Organization 1996, *Technical report series 861: Integration of health care delivery. Report of WHO study group*, WHO, Geneva.

<sup>13</sup> Department of Human Services 2007, *Framework for the Victorian General Practice Liaison program*, State Government of Victoria, Melbourne, pp. 10–13.

<sup>14</sup> Partnerships can encompass: networking involving the exchange of information for mutual benefit; coordinating involving exchanging information and altering activities for a common purpose; cooperating involving exchanging information, altering activities and sharing resources; and collaborating, which, in addition to above activities, includes enhancing the capacity of the other partner for mutual benefit and common purpose. VicHealth 2008, *The partnerships analysis tool for partners in health promotion*, Carlton, p. 3.

### Areas of interest for collaborative partnerships

The common areas of interest for health services, GP divisions and local general practices engaged in establishing an AHGP clinic include:

- planning of new services
  - service profile of after-hours primary medical services
  - endorsement from local GPs
  - relationships with well-located AHGP clinics
- continuing professional development
- GP workforce strategies
  - staffing the service
  - centralised employment management services
- clinical governance
- connecting patients with a regular GP
- information exchange between the health service and local practices
  - notification and recall processes
  - referrals from local GPs
  - promoting the service
- providing and managing physical facilities
- reporting and evaluation.

Health services and their local GP divisions and general practices may formalise their collaborative partnerships around co-located AHGP clinics in a variety of ways including:

- memoranda of understanding
- service and funding agreements
- the clinic's governance structure
- endorsement through an annual plan of GPL service.

### 3.3 Criteria for establishing new services

Health services and their local GP divisions and general practices have a joint responsibility to determine the need for emergency after-hours medical care in their locality. A formal planning process involving all parties needs to be undertaken to evaluate the need and support for an AHGP clinic and to identify the various options for providing after-hours primary medical services in the area.

The planning process for new services needs to be informed by the role and supporting principles outlined in this framework and the criteria set out in following box.

#### Criteria for establishing new services

The planning criteria for new AHGP clinics include:

- a verified shortage of existing AHGP services in the catchment area of the health service
- a high demand for ED services in the after-hours period by consumers who could be suitably treated by GPs
- a clear commitment from the health service to establish an AHGP service
- endorsement of proposals from local GPs and the relevant divisions of general practice
- verification that a co-located AHGP clinic would not create unfair competition with existing providers of after-hours services in the local area
- support from local GPs in the form of referrals to, and staffing of, the proposed service
- the existence of an extended-hours general practice located adjacent to or on a major transport route to the hospital and the capacity to establish a formal relationship between the clinic and the health service.

### 3.4 Engaging well-located AHGP clinics

In instances where there is an extended-hours general practice located adjacent to or on a major transport route to a hospital ED,<sup>15</sup> the health service, in conjunction with the local GP division, may explore the possibility of establishing a formal agreement with the practice on the provision of after-hours primary medical care.<sup>16</sup>

Any agreements would need to be consistent with the requirements of the *Trade Practices Act 1974* and other regulatory regimes<sup>17</sup> that seek to maintain fair competition and trading between GP practices and ensure practices are not damaged through the anti-competitive actions of others.<sup>18</sup> This is of particular importance where there is more than one practice providing an extended-hours service in the vicinity of the hospital ED.

<sup>15</sup> GP clinics providing after-hours services that are located near to or on a major transport route to an acute hospital ED may be described as 'well located' due to their proximity to acute services.

<sup>16</sup> Refer to section 5.2.5 and Appendix 3 for a sample agreement.

<sup>17</sup> Trade Practices Act and regulatory bodies such as the Australian Competition and Consumer Commission.

<sup>18</sup> Australian Competition and Consumer Commission 2004, *Information kit for the medical profession*, viewed 22 February 2009, <<http://www.accc.gov.au/content/index.phtml/itemId/575092>>.

Formal agreements between health services and well-located AHGP clinics are to incorporate a section on clinical governance. This document outlines a clinical governance framework and a methodology for determining responsibility for governance and medico-legal risk to assist services with this requirement.<sup>19</sup>

### 3.5 Approval processes

Once the planning process is complete, health services, in conjunction with local GP divisions and GPs, may prepare a business case for establishing a new co-located AHGP clinic. Key elements to be addressed in the business case include:

- information relevant to the planning criteria
- its responsiveness to local community needs and priorities
- its service delivery model
- a sufficient and appropriately qualified GP workforce
- proposals for physical facilities
- capital funding requirements
- the business and governance structure of service
- its capacity to ensure continuity of care between the clinic and the patient's usual GP or health care providers
- a commitment to quality of care, including accreditation<sup>20</sup>
- a commitment to financial sustainability of service
- a proposed annual budget for the service covering the contributions of all revenue sources including Australian Medicare, Commonwealth General Practice After-Hours Program (GPAHP) grants and state funding.<sup>21</sup>

Once the business case is endorsed, the health service may submit the proposal to the Commonwealth Department of Health and Ageing for funding under the GPAHP. The Victorian Department of Health is to be informed as part of the service planning process.

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<sup>19</sup> Refer to section 5.4 and Appendix 4.

<sup>20</sup> Refer to section 5.4 on clinical governance.

<sup>21</sup> Department of Health and Ageing 2008–09, *General practice after-hours program: program guidelines*, Australian Government, Canberra.



## 4.0 Service delivery

This section of the framework outlines key aspects of service delivery for co-located AHGP clinics, including the scope of the service, access and continuity of care. The individual and shared responsibilities of health services and general practices in delivering this model of care are a major focus of this section.

### 4.1 Hours of operation

Co-located AHGP clinics are to provide services outside usual business hours. Generally, after hours is considered to include services provided on a public holiday, a Sunday, before 8am or after 12pm on a Saturday, or anytime other than between 8am and 6pm on a weekday.<sup>22</sup>

Clinics are not required to provide services during the overnight period between 11pm and 8am.

### 4.2 Scope of the service

Co-located AHGP clinics are to provide services to consumers who present with acute symptoms that can be treated within the usual scope of general practice.

Clinics and the health services may determine the scope of the service in conjunction with the GPs delivering the service, recognising the need to respect and support the independence and clinical autonomy of GPs,<sup>23</sup> particularly in the areas of referrals to other health professionals and the ordering and provision of pathology, imaging and other diagnostic services. The range of services that may be provided by a co-located AHGP clinic include:

- medical consultation
- fracture management
- minor procedures
- electrocardiogram (ECG)
- management of minor injury and trauma
- referral and notification
- referral to on-site radiology and/or pathology.

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<sup>22</sup> *The Health Insurance Act defines after-hours care for purposes of MBS payments as 'attendance on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or anytime other than between 8am and 8pm on a weekday', (Health Insurance (General medical services table) Amendment regulations 2007 (no. 1)). See: Department of Health and Ageing 2008–09, General practice after hours program: program guidelines, Australian Government, Canberra, p. 6.*

<sup>23</sup> *Royal Australian College of General Practice 2005, Standards for general practices, 3rd edition, RACGP, Melbourne, Criterion 1.4.2.*

Specialist medical services,<sup>24</sup> home visits and repeat visits that constitute continuing, comprehensive and coordinated primary medical care and an ongoing relationship between the patient and the practice are not within the scope of practice of a co-located AHGP clinic.<sup>25</sup> The clinic can work with the GPL service to establish processes to assist people without a regular GP to link with a local practice.<sup>26</sup>

Specialist advice may be sought from senior medical staff in the ED or other hospital specialties. Health services, in conjunction with co-located clinics, would need to establish processes whereby clinic GPs could obtain advice from senior medical staff in the ED or other specialties in the hospital on request.

The scope of services provided by a clinic would form part of formal agreements established between health services and GP practices providing a co-located AHGP clinic and would need to be consistent with the skills and competencies of the GPs working in the clinic and the clinical governance framework outlined in section 5.4.

### 4.3 Physical facilities

The co-located AHGP clinic is to be located within a public hospital, near or adjacent to (but physically separate from) the hospital ED.

Health services are to provide the physical facilities and equipment required to facilitate a working and clinical environment for GPs and practice staff that facilitates the maintenance of relevant ethical and professional standards and a high standard of patient care. Medical and workplace facilities are to be at a standard consistent with industry accreditation standards.

The physical facilities are to reflect the environment and character of a community-based general practice and may include a separate reception and waiting area for patients and a procedures room. Buildings and facilities need to be accessible to people with a disability and should comply with accessibility standards.<sup>27</sup>

The environment in which primary medical services are provided should be safe for staff and patients. Crime prevention through environmental design (CPTED) principles<sup>28</sup> should be applied in the course of planning, establishing and maintaining clinic facilities. CPTED and other design features can be employed to ensure patients are aware that the clinic is a separate entity located within the hospital.<sup>29</sup>

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<sup>24</sup> As defined by Medicare Australia for purposes of MBS funding. Refer to Department of Health and Ageing, 2007, *op. cit.*, p. 3.

<sup>25</sup> It is recognised that in a few instances the clinic may establish an ongoing care relationship with people whose psychosocial situation precludes regular contact with a GP. In these cases the clinic may either provide care on an ongoing basis or refer the client to the ED to facilitate access to appropriate resources.

<sup>26</sup> *General Practice Victoria 2008, GP Liaison Program report 2007–2008, GPV, Melbourne, p.19.*

<sup>27</sup> *Standards Australia 2009, Australian Standard 1428, viewed 27 February 2009, <www.standards.org.au>.*

<sup>28</sup> *WorkSafe Victoria 2008, Prevention and management of aggression in health services, Edition No.1, pp. 11–19.*

<sup>29</sup> *The separation of facilities will support accreditation of the clinic in accordance with RACGP Standards.*

## 4.4 Evidence-based practice

Co-located AHGP clinics are to provide services based on the best available evidence and deliver care in an effective manner that results in improved health outcomes for patients.

Clinics and health services are to work on a collaborative basis to ensure GPs working in the clinics have access to relevant supports that facilitate the provision of best evidence-based practice, including:

- clinical practice guidelines<sup>30</sup>
- consultation with ED and other hospital physicians
- relevant ED education programs
- appropriate medical record-keeping system
- robust clinical risk management systems.

## 4.5 Access to services

Current community practice allows consumers direct access to GP services and hospital EDs on a self-referral basis. Consumers may also access services following advice and information from health practitioners about the most appropriate service for their care needs.

Consistent with these practices' government regulations<sup>31</sup> and access policies,<sup>32</sup> consumers seeking emergency primary medical care may have direct access to a co-located AHGP clinic and/or they may make an informed choice to attend after presenting at a hospital ED.

Health services and co-located AHGP clinics may establish policies and guidelines to govern consumer access and their movement between services. Policies would be based on a consideration of:

- its capacity to manage clinical risk
- patient flow within the ED
- a potential increase in demand for hospital services
- the viability and sustainability of the clinics
- collaborative arrangements with local GP divisions and general practitioners
- Commonwealth and state government funding requirements.

Consumer access to co-located AHGP clinics may be facilitated in a variety ways including signage, service information, care pathways and advice from local GPs and hospital ED triage staff. Local access policies and guidelines established by health services and their co-located clinics will inform each of the access arrangements addressed in the following sections.

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<sup>30</sup> *Therapeutic Guidelines Limited, viewed 23 April 2009, <[www.tg.org.au](http://www.tg.org.au)>.*

<sup>31</sup> *Campbell Research & Consulting 2007, op. cit., Appendix 1, pp. iii-iv.*

<sup>32</sup> *Better faster emergency care, op. cit., p.3.*

### 4.5.1 Signage

Signage relating to co-located AHGP clinics needs to provide clear directions to consumers about what to do when they arrive, where the clinic is located and how it may be accessed. Signage needs to be consistent with the guidelines published in the department's *Emergency signage improvement initiatives* document.<sup>33</sup>

Signage will reflect the access policy established by the health service and the clinic and will facilitate either direct consumer access to the clinic and/or access after obtaining advice from the ED triage service.

In developing signage for co-located AHGP clinics the following factors need to be considered:

- duty of care and the reputation of health service
- ownership and governance structures of co-located AHGP clinics
- formal agreements around direct consumer access to clinics
- the availability of well-located AHGP clinics located in close proximity to the hospital ED and legislative requirements that seek to prevent unfair competition with existing providers of after-hours services in the local area.<sup>34</sup>

Signage is to be addressed as part of formal agreements established between health services and GP practices providing a co-located AHGP clinic and is to be consistent with the clinical governance framework outlined in Appendix 3.

### 4.5.2 Service information

Information about the services provided by co-located AHGP clinics may be used to facilitate access to the clinics. The information provided needs to:

- be accessible, accurate and reliable
- be provided in a consistent manner
- empower consumers to make informed choices about treatment options.

Information provision is to be supported with translated material, culturally sensitive practice and training for front-of-house staff in both EDs and GP clinics. The information may be distributed in printed and electronic forms through ED waiting rooms, GP divisions, GP practices, health services, NURSE-ON-CALL (NOC) and the *Human Services Directory* (HSD).

Refer to section 4.5.4 for further details on information provided by ED triage services.

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<sup>33</sup> Department of Human Services 2006, *Emergency signage improvement initiatives/emergency departments, State Government of Victoria, Melbourne*. Available at <[www.health.vic.gov.au/emergency/emerg\\_sign.pdf](http://www.health.vic.gov.au/emergency/emerg_sign.pdf)>.

<sup>34</sup> Australian Competition and Consumer Commission 2004, *Information kit for the medical profession, viewed 29 February 2009*, <<http://www.accc.gov.au/content/index.phtml/itemId/575092>>

### 4.5.3 Information from local general practitioners

Under the Royal Australian College of General Practice (RACGP) *Standards of general practice*, GPs are required to arrange an alternative system of care for their patients when they cannot safely or reasonably deliver that care outside normal opening hours. These arrangements need to be clearly communicated to patients of the practice.<sup>35</sup>

Distinct from these arrangements, GP practices may also provide information about local co-located AHGP clinics to facilitate consumer access and choice.

### 4.5.4 Information and advice from hospital emergency departments

When a consumer presents to a hospital ED either on their own initiative or on referral from a primary health practitioner, triage undertakes an initial screening process that determines a consumer's risk, the type of treatment they require and their priority for service.

Following the initial screening the triage service may, where appropriate, provide consumers with information and advice on various other treatment options including a co-located AHGP clinic. In accordance with the Australian Health Care Agreement between Victoria and the Commonwealth, ED triage staff may advise consumers about alternative options for care. The ED must provide treatment if the consumer chooses to be treated at the hospital.<sup>36</sup>

The advice and information provided by triage should empower consumers to make informed choices about their treatment options and could include information about:

- various treatment options
- the range and availability of other services
- waiting times
- costs
- access to ED services where alternative care proves inappropriate.

### 4.5.5 Information and advice from co-located after-hours general practice clinics

Co-located AHGP clinics may determine that a consumer is not suitable for treatment in the clinic. The clinic may direct people to present to the ED where the clinic deems it cannot deliver the required care in an effective manner. This applies to consumers presenting directly to the co-located clinic and those attending following advice from triage.

The co-located clinic, in conjunction with the health service, may establish screening processes and criteria to support decision making by practice staff and to minimise clinical risk to consumers.<sup>37</sup>

Co-located AHGP clinics may also inform consumers about the services provided by the co-located clinic and other relevant services.

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<sup>35</sup> RACGP, 2005, *op.cit.*, Standard 1.1 Criterion 1.1.4, pp. 15–17.

<sup>36</sup> Campbell Research & Consulting 2007, *op. cit.*, Appendix 1, pp. iii–iv.

<sup>37</sup> Dandenong District Division of General Practice 2005, *Triage support guide handbook A guide for non-clinical staff in general practice*, Melbourne.

#### 4.5.6 Screening criteria

Health services, in conjunction with co-located clinics, may establish criteria to support the screening process undertaken at ED triage and the provision of advice to consumers. The criteria would be designed to support clinical decision making, minimise clinical risk and ensure ED triage occurs in a timely manner.

Screening criteria would be informed by:

- the scope of the co-located AHGP practice including clinical autonomy of GPs
- triage assessment
- established care pathways for delivering evidence-based best care practice.

The screening criteria would identify consumers at significant clinical risk and who could not be safely or appropriately managed in a co-located AHGP clinic and may include consumers who are:

- re-presenting to the ED
- experiencing significant pain and may require procedural sedation
- presenting with significant comorbidities or high-risk historical variables
- victims of violence
- presenting with substance abuse or complex mental health or social issues.

Other considerations would include:

- consumers presenting without a Medicare card
- overseas visitors who cannot access Medicare services.

The co-located clinic, in conjunction with the health service, may establish screening criteria to support decision making by GPs and other practice staff about the suitability of treating consumers in the clinic. The criteria would be consistent with the scope of practice of the clinic and its GPs and evidence-based best care practice.

The screening criteria for both services would form part of a formal agreement between health services and co-located clinics and would be supported by:

- information for consumers that facilitates informed choices
- training for front-of-house staff in both the ED and co-located clinic
- shared clinical placements
- clinical governance arrangements.

The screening criteria needs to be reviewed periodically in accordance with data on patient flows between the ED and the clinic.

## 4.6 Continuity of care

In general practice continuity of care is distinguished by two core elements: care over time and the focus on individual patients. There are various types of continuity promoted in a general practice including:

- relational continuity where there is a sense of affiliation between the patient and the GP
- management continuity where there is consistency of care by the various people involved in the patient's care
- informational continuity where there is continuity of information across health care events, particularly through documentation and handover.<sup>38</sup>

Co-located AHGP clinics provide acute, episodic care on a walk-in basis and therefore do not facilitate an ongoing relationship between the consumer and the clinic's GP. The clinics do have a role in assisting the consumer's regular practice to maintain continuity and consistency in patient care through effective communication subject to the consumer's consent.

The clinics are to promote a consistent approach within the practice to the diagnosis and management of conditions, illnesses and injuries treated within the scope of the service. Consistency between multiple GPs and other practice staff may be facilitated through:

- strong GP leadership
- a practice manager and established systems for providing clinical care
- regular meetings to discuss clinical care
- access to clinical practice guidelines.

Health services and co-located AHGP clinics are to promote consistency between the clinic and the ED by ensuring GPs have access to consultations with ED and other hospital physicians and can participate in ED education programs.<sup>39</sup> Notifications and exchange of consumer information between the ED and the clinic ensure there is continuity of information across both episodes of care and health providers.

### 4.6.1 Notifications and transfers between the ED and the co-located clinic

Health services and clinics are to notify one another about consumer movements between the ED and the AHGP clinic.

Once a consumer presenting to an ED elects to be treated at a co-located AHGP clinic, the ED triage service is, wherever practical, to notify the clinic the person will be attending.

Where a co-located AHGP clinic determines a consumer is unsuitable for treatment in the clinic and directs the consumer to present to the ED, the clinic will notify triage that the consumer will be attending. Health services are to facilitate the timely treatment of these consumers by ensuring triage takes the time they have spent waiting at the clinic into account when prioritising patients in the ED queuing system. Consumers are to be informed about this arrangement during discussions about their treatment options.

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<sup>38</sup> RACGP 2005, *op.cit.*, Standard 1.5 Criterion 1.5.1–1.5.4, pp. 28–34.

<sup>39</sup> Refer to sections 4.2 and 5.5.1.

Health services and co-located AHGP clinics are to establish processes for transferring clinic patients to the ED in a medical emergency or where the consumer's condition deteriorates while they are at the clinic.

#### 4.6.2 Information exchange between the ED and the co-located clinic

Historical patient health information can assist GPs in understanding the relevant components of a consumer's care and reduce the risk of inappropriate management. Health services will have access to a patient record where the consumer has previously attended the hospital and this information may assist GPs working in the co-located AHGP clinic.

Health services, in conjunction with co-located AHGP clinics, are to develop policies and procedures to govern the exchange of patient health information. Policies would be based on a consideration of:

- legislative requirements covering consumer consent, privacy and confidentiality<sup>40</sup>
- the need to actively engage consumers in their own care and treatment
- health service and clinic IT systems
- clinical governance arrangements.<sup>41</sup>

Information exchange is to be addressed as part of formal written agreements established between health services and organisations governing co-located AHGP clinics and is to be consistent with legislative and regulatory requirements around privacy and the clinical governance framework outlined in this document.

Consumers and carers are to be informed about their rights to privacy and confidentiality and the extent to which information may be shared between the health service and the clinic. Procedures are to be established that enable consumers to veto the exchange of information between public and private services.

#### 4.6.3 Notifications and information exchange between the co-located clinic and other general practices and services

Co-located AHGP clinics have a role in assisting the consumer's regular GP practice to achieve a consistent approach to patient care. This may be primarily achieved through effective communication between the co-located AHGP clinic, the consumer and the consumer's usual GP.

Co-located AHGP clinics are to establish patient health records documenting consultations undertaken at the clinic. The name and details of the consumer's usual GP and the time and date of the consultation are to be included in the record to facilitate notifications and information exchange.<sup>42</sup>

Co-located AHGP clinics are to forward a legible summary<sup>43</sup> of any consultations at the clinic to the consumers' usual GPs. Summaries may include a range of information such as:

- time and date of consultation

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<sup>40</sup> *Your information: its private*; <[www.health.vic.gov.au/archive/archive2006/hdms/index.htm](http://www.health.vic.gov.au/archive/archive2006/hdms/index.htm)>; <[www.health.vic.gov.au/pcps/publications/index](http://www.health.vic.gov.au/pcps/publications/index)>; <[www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au)>

<sup>41</sup> Refer to section 5.4.1.

<sup>42</sup> RACGP Standards, Criterion 1.7.1 and 1.7.3

<sup>43</sup> RACGP Standards, Criterion 1.7.3



- the consumer's reason for the consultation
- diagnostic tests ordered
- relevant clinical findings
- diagnosis
- recommended management plan and process of review
- any prescribed medication
- any relevant preventive care undertaken
- documentation of any referral to other health care providers or health services
- any special advice or other instructions
- details of who conducted the consultation.

Co-located AHGP clinics are to facilitate consumer access to hospital and other community-based services for ongoing care requirements. Referrals requesting further assessment, care or treatment may be made either by the consumer with appropriate information, advice and decision support from the clinic or by practice staff on behalf of a consumer as an assisted referral.<sup>44</sup> Co-located AHGP clinics may arrange for assisted referrals to be coordinated through the consumer's usual GP where clinically appropriate and with consumer consent. GP clinical leaders in co-located AHGP clinics are to establish monitoring systems that ensure referrals are made during business hours and patients are notified.<sup>45</sup>

Clinics are to establish processes to inform consumers about their rights to privacy and confidentiality and obtain their consent to any exchange of information. Where the consumer does not have a regular GP the clinic may assist them to link with a local practice. The health service may assist the clinic with these processes through its GPL service.<sup>46</sup>

#### 4.6.4 Follow-up of diagnostic tests and results

The information gained from diagnostic tests and results can have considerable impact on patient care, particularly when seen in the overall context of the patient's history and presenting problems. As co-located AHGP clinics provide acute, episodic care that does not support an ongoing relationship between the consumer and the GP, suitable follow-up systems are required to ensure continuity and consistency of care.

Co-located AHGP clinics, in conjunction with health services, are to develop policies and procedures to govern the follow-up, review and distribution of diagnostic test results ordered through the clinic, particularly where pathology and imaging services are provided by the hospital or when a patient is transferred to the ED.

The policies and practice management systems are to ensure:

- all received diagnostic test results and clinical correspondence relating to a consumer's clinical care are reviewed
- the consumer's regular GP is notified about investigations undertaken and the results

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<sup>44</sup> Department of Human Services 2008, *Guidelines for the Victorian emergency department care coordination program*, State Government of Victoria, Melbourne, pp. 21–22.

<sup>45</sup> Refer to sections 5.3 and 5.4.1.

<sup>46</sup> Refer to section 4.2.

- clinically significant tests and results are followed up with consumers
- consumers are able to contact the clinic to follow up on test results
- consumers are aware of the clinic's follow-up arrangements and how they operate<sup>47</sup>
- the ED is notified about test results when a patient is transferred from clinic to the ED.

Clinics are to convey results to consumers in a manner that promotes understanding and facilitates informed decision making, including using interpreters if necessary.<sup>48</sup> Co-located clinics are to obtain and document consumer consent before transferring identifiable patient health information.<sup>49</sup>

As part of their clinical governance responsibilities, GP clinical leaders in AHGP clinics have a key role in establishing and monitoring systems that ensure abnormal results are followed up, patients are notified, treatment commenced and any referrals arranged, particularly where consumers do not want their regular GP notified.<sup>50</sup>

## 4.7 Medication

Consumers attending a GP practice who require medication are issued with a prescription that can be filled at any authorised pharmacy. GPs may also administer medicines from a doctor's bag (or resuscitation bag) maintained for medical emergencies.<sup>51</sup>

As co-located AHGP clinics operate outside business hours and consumers may not be able to access a community-based pharmacy until the following day there may be instances where consumers require an initial dose of the prescribed medication. To accommodate these contingencies, co-located AHGP clinics and health services may consider:

- providing access to a hospital pharmacy service
- establishing a pharmacy imprest service supported by the hospital pharmacy service.

Where a co-located AHGP clinic has an imprest service, health services and clinics are to develop policies, procedures and quality assurance systems to govern the safe and secure handling of medicines in the clinic in accordance with legislative requirements and best practice. This will include establishing risk and control systems covering ordering, delivery, storage, dispensing, issue, supply, administration and disposal of medicines within and between the AHGP clinic and the hospital pharmacy.

Pharmacy services are to be addressed as part of formal written agreements established between health services and GP practices providing a co-located AHGP clinic, and are to be consistent with the clinical governance framework outlined in this document.

The type of medicines available through the imprest will depend on the scope of the practice, the availability of community-based after-hours pharmacy services, the clinical conditions likely to be encountered and the shelf life, storage requirements, cost and the size of the medications available in the imprest.

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<sup>47</sup> RACGP, *Standards op. cit.*, *Criterion 1.5.4*

<sup>48</sup> RACGP, *Standards op. cit.*, *Criterion 1.2.2 and 1.2.3.*

<sup>49</sup> RACGP, *Standards op. cit.*, *Criterion 4.2.1*

<sup>50</sup> Refer to section 5.4.1.

<sup>51</sup> RACGP, *Standards op.cit.*, *Criterion 5.2.2.*

## 5.0 Structure, governance and management of co-located clinics

The following section of the framework addresses the governance, management and organisational structures supporting the co-located AHGP clinics operating in Victoria. Co-located AHGP clinics may be structured in a variety of ways to accommodate different approaches to the ownership, governance, management and business models employed in AHGP services. The structures are designed to support a collaborative approach to the delivery of after-hours primary medical care.

### 5.1 Private practices

In accordance with the *Health Insurance Act 1973*<sup>52</sup> and related Regulations, co-located AHGP clinics are to operate as private billing practices participating in the Commonwealth Medicare program. Clinics are to be registered with Medicare Australia and have a Medicare provider number as a place of practice where GP services are provided.<sup>53</sup>

GPs working in a co-located AHGP clinic are practising in a private capacity and are to utilise their own unique Medicare provider number associated with the co-located AHGP clinic. GPs are not to receive other government funding for their professional services.<sup>54</sup> As part of an employment contract, GPs may donate their MBS earnings to the practice and be remunerated on a contractual basis.<sup>55</sup> Co-located AHGP clinics may not be established as MBS-billed specialist clinics.<sup>56</sup>

GPs may bill patients privately or bulk bill Medicare. In the latter case, patients assign their right to a benefit to the practitioner as full payment for the medical service. In this case the GP or the clinic cannot make any additional charge for the service provided.<sup>57</sup> Co-located AHGP clinics may operate as a mixed-billing practice, bulk billing consumers with a Commonwealth concession and children under 16 years, and charging other consumers a co-payment.

Health services and the organisations governing the co-located AHGP clinics are to determine the billing model employed by the clinic after considering and balancing the need to provide accessible services and the capacity of the clinic to provide viable, cost-effective services that are sustainable on a long-term basis. The billing model is to be incorporated into the formal written agreement established between the organisations.

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*52 Health Insurance Act 1973, subsection 19(2) which reads: A Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under and arrangement with the Commonwealth; a State, local governing body or an authority established by a law of the Commonwealth, a law of a State or law of an internal Territory.*

*53 Medicare Australia, Information sheet for an initial Medicare provider number for a medical practitioner application, viewed 7 April 2009, <[www.medicare.gov.au/provider/business/files/ma\\_0266\\_app\\_for\\_initial\\_medicare\\_provider\\_number\\_general\\_practitioner.pdf](http://www.medicare.gov.au/provider/business/files/ma_0266_app_for_initial_medicare_provider_number_general_practitioner.pdf)>*

*54 Medicare Australia, op. cit., p. 1.*

*55 This type of remuneration model is utilised in specialist clinics. Refer to Department of Human Services 2008, Specialist clinics in public hospitals: A resource kit for MBS-billed services, State Government of Victoria Melbourne.*

*56 For the purposes of this resource kit, MBS-billed specialist clinics do not include: non-admitted services provided by GPs in public hospitals; or non-admitted services provided on an emergency (unplanned) basis in either a public hospital emergency department or some other setting in a public hospital, provided by a medical practitioner with rights of private practice. See: Department of Human Services 2009, Specialist clinics in public hospitals A resource kit for MBS-billed services, State Government of Victoria, Melbourne, p. 5.*

*57 This means that if the practitioner bulk bills, the patient cannot be charged a booking fee, an administration fee, a charge for bandages or record keeping, or a charge by the practitioner's service company, viewed 7 April 2009, <<http://www.medicareaustralia.gov.au/provider/pubs/mediguide/section5/billing.jsp>>*

Consumers are to be informed about any costs associated with attending a co-located clinic.<sup>58</sup>

## 5.2 Corporate governance of co-located clinics

The governing entity of a health care organisation has ultimate responsibility and authority for its strategic direction, financial affairs, policies, program implementation and performance.<sup>59</sup>

Effective corporate governance requires organisations to have:

- strong leadership and sound strategy
- clear understanding of their respective roles and responsibilities
- sensible and sound delegations of authority
- effective monitoring of organisational performance
- clear systems of accountability and effective supporting structures.<sup>60</sup>

The key areas of relevance for corporate governance are:

- funding and financial and performance management
- organisational role and strategic direction
- policies and procedures
- human resource management
- occupational health and safety
- information management
- physical facilities, equipment and supplies
- stakeholder management.

Where a single organisation is responsible for providing a service, the governing entity of that organisation is responsible for the service. In a collaborative partnership where more than one organisation is responsible for providing a service, each of the organisations involved will have individual and joint governance and management roles and responsibilities for the services they provide to consumers.<sup>61</sup>

### 5.2.1 Corporate governance of health-service-operated clinics

In instances where a health service owns and operates the co-located AHGP clinic the health service, and ultimately its board, has sole corporate governance responsibility for the service. As the co-located clinics operate as private billing practices participating in the Commonwealth Medicare program and may access both state and Commonwealth funding, the clinics need to operate within state and Commonwealth policy parameters and collaborate with key stakeholders including local GPs and divisions, General Practice Victoria (GPV) and the RACGP.

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<sup>58</sup> Refer to section 4.5.4.

<sup>59</sup> *Our community 2008, Code of governance for the Australian community sector, viewed 8 May 2009, <[www.ourcommunity.com.au/boards](http://www.ourcommunity.com.au/boards)>.*

<sup>60</sup> *DLA Phillips Fox 2008, Development of a clinical governance framework and toolkit – Co-located and well-located emergency departments and general practices. Presentation to stakeholder workshop, 6 November 2008.*

<sup>61</sup> *DLA Phillips Fox 2009, Clinical governance of co-located and well-located after-hours general practice services – A framework and toolkit, Melbourne. Available at <[www.health.vic.gov.au/emergency](http://www.health.vic.gov.au/emergency)>.*

From a governance perspective, health services that own a co-located clinic are required to manage these stakeholder relationships effectively and ensure conditions of funding are fulfilled. Health services may formalise relationships with their local GP divisions and GPs utilising a memorandum of understanding.<sup>62</sup>

### 5.2.2 Corporate governance of collaborative partnerships

In Victoria, public health services are corporations formed under the *Health Services Act 1988* and are governed by a board of directors. As private practices, co-located AHGP clinics may be structured and organised in a variety of ways. The identity of the governing entity will depend on the organisational structure of the practice and may include practices operated and managed by:

- a sole practitioner
- a cooperative of local GPs with an independent board of directors
- an independent company limited by guarantee managed by a board of directors including nominees from the health service and local division

In these instances, co-located AHGP clinics are provided on a collaborative basis involving a partnership between a public health service and an organisation providing a general practice service. Each of the organisations has individual and joint governance and management roles and responsibilities for the services they provide to consumers.<sup>63</sup>

### 5.2.3 Form of collaboration

The relationship between the partnership organisations and their respective roles and responsibilities is to be established in a formal written agreement. The agreement is to address key areas of common interest to both organisations at the corporate governance level and may include:

- the vision and purpose of the collaboration
- a strategic plan with goals, strategies and actions for the future development of the service
- frameworks, policies and standards
- the role, function and scope of the service
- clinical governance
- the funding and financial viability of the clinic
- performance management and accountability
- leasing, physical facilities and equipment
- stakeholder relationships.

Other matters to be addressed in a formal written agreement between the health service and the co-located AHGP clinic have been identified in earlier sections of this report and include scope of practice, signage, screening criteria, information exchange and pharmacy services.

Appendix 3 contains a sample agreement developed by DLA Phillips Fox that can be utilised by a collaborative partnership involving a health service and an organisation governing a co-located AHGP clinic.

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<sup>62</sup> Refer to section 3.3.

<sup>63</sup> DLA Phillips Fox 2009, *Clinical governance framework and toolkit*, op. cit. p. 11.

### 5.2.4 Liaison structure

Health services and the organisations governing the co-located AHGP clinic should establish a liaison committee comprised of representatives from partnership organisations to facilitate collaboration and the delivery of quality services.

The functions of the committee in relation to corporate governance may include:

- monitoring and evaluating the performance and strategic direction
- overseeing the allocation of organisational roles, delegations and responsibilities
- considering and analysing risks and opportunities and overseeing the development and implementation of a shared risk management system
- establishing and reviewing policy and procedures
- establishing and maintaining effective communication and cooperation between partnership organisations
- engaging key stakeholders<sup>64</sup>
- overseeing occupational health and safety
- facilitating ongoing collaboration on operational, management and administrative matters of joint interest.

The liaison committee is to also have a range of clinical governance functions.<sup>65</sup>

Members of the liaison committee are to have adequate delegated authority to fulfil these functions. The structure, operation and reporting arrangements of the committee are to form part of the written agreement between a health service and the organisation governing the co-located AHGP clinic.<sup>66</sup>

### 5.2.5 Strategic leadership and planning

Health services and the organisations governing the co-located AHGP clinic may establish a strategic plan that incorporates a vision, purpose and agreed strategies and actions for the clinic. The plan would inform the operation and future development of the clinic and provide a basis for monitoring and evaluating the progress of the collaboration over time. The plan would also assist with the systematic allocation of roles and responsibilities between the health service and the co-located AHGP clinic.

### 5.2.6 Allocation of roles and responsibilities at the organisational level

Health services and the organisations governing the co-located AHGP clinic are to clearly articulate their operational responsibilities, duty of care and responsibilities for premises and the safety of staff and consumers.

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*64 Both organisations in the partnership are required to effectively manage stakeholder relationships with local GPs and divisions and ensure conditions of Commonwealth and state funding are fulfilled. Health services may formalise relationships with their local GP divisions and general practices utilising a memorandum of understanding or the GPL service annual plan. Refer to section 3.3.*

*65 Refer to Appendix 4, Domain 1.*

*66 Appendix 3 section headed Liaison committee.*

Where co-located AHGP clinics are provided through a collaborative partnership, health services and the organisations governing the clinic health services are to clearly identify which organisation is responsible for each aspect of the service and which carries the medico-legal risk. This includes identifying which service elements are the responsibility of one provider only and which are delivered at the interface between two providers.

The legal and organisational responsibility for service provision, facilities and occupational health and safety will vary according to the structure of the GP organisation providing the co-located AHGP clinic. The companion document *Clinical governance of co-located and well-located after-hours general practice services – A framework and toolkit*<sup>67</sup> outlines a methodology and the associated legal opinion prepared by DLA Phillips Fox to assist health services and GP organisations to determine their respective and joint governance, legal and organisational responsibilities for co-located AHGP clinics.

The companion document also includes information on well-located co-located AHGP clinics to assist health services seeking to establish a formal agreement with a general practice providing after-hours services that is located adjacent to or on a major transport route to a hospital ED.<sup>68</sup>

The governance and medico-legal responsibilities are to be incorporated into the formal written agreement established between health services and organisations providing co-located clinics.

The Co-located AHGP Liaison Committee is to oversee the process of allocating roles and responsibilities at the organisational level.

### 5.2.7 Occupational health and safety

Health services and the organisations governing co-located AHGP clinics are to provide a safe environment for staff and consumers using the clinic in accordance with the *Occupational Health and Safety Act 2004*.

The Co-located AHGP Clinic Liaison Committee is to ensure the occupational health and safety system that applies to the co-located AHGP clinic and the implementation responsibilities are clearly articulated in an occupational health and safety plan. The plan needs to define risks, controls and the roles and responsibilities of those implementing the plan. Monitoring and reporting arrangements to oversee the effectiveness of the plan<sup>69</sup> are also to be established.

## 5.3 Practice management and administration

The co-located AHGP clinic is responsible for the operational management and administration of the practice under the direction of the owner and governing body.

In accordance with the RACGP Standards,<sup>70</sup> and the established code for the management and administration of medical practices,<sup>71</sup> the clinic should work with GPs to plan and determine

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<sup>67</sup> See <[www.health.vic.gov.au/emergency](http://www.health.vic.gov.au/emergency)>.

<sup>68</sup> Refer to section 3.5.

<sup>69</sup> DLA Phillips Fox 2009, *Clinical governance framework and toolkit*, op. cit., pp. 22–23.

<sup>70</sup> RACGP 2005, op. cit., Standard 1.4, Criterion 1.4.2.

<sup>71</sup> Royal Australian College of General Practice 2001, *A code of conduct for corporations involved in the provision of management and administrative services in medical centres in Australia*, RACGP, South Melbourne.

the systems the practice uses to provide clinical care. Systems are to respect and support independence and clinical autonomy of GPs, including decisions affecting clinical care such as:

- referrals to other health professionals
- ordering and provision of pathology, imaging and other diagnostic services
- appointment scheduling and patient load
- complexity, length and style of consultations
- movement of patients between the ED and the clinic.

The clinic may be operated by a practice manager experienced in general practice (see section 5.5).

Health services are to work with co-located clinics to create a supportive working and clinical environment for GPs and practice staff, one that facilitates the maintenance of relevant ethical and professional standards and a high standard of patient care. In a co-located clinic where large numbers of GPs work part time, outside business hours, with limited interaction as a peer group, a GP clinical leader may be appointed to:

- provide strong medical cultural leadership
- be a focus for communication with GPs and between the clinic and the ED
- take a lead role in clinical governance activities.

In co-located clinics formed through a collaborative partnership, the GP clinical leader is to participate in the Co-located AHGP Clinic Liaison Committee.<sup>72</sup>

## 5.4 Clinical governance

Clinical governance is defined as ‘the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers’.<sup>73</sup> It is the governance of clinical care.<sup>74</sup>

Clinicians and clinical teams are directly responsible and accountable for the safety and quality of care they provide. The governing entity and management are responsible and accountable for ensuring systems and processes are in place to support clinicians in providing safe, high-quality care and that they participate in clinical governance activities.<sup>75</sup>

The key elements of clinical governance are:

- strategic leadership of clinical services
- effective delegation of authority and responsibility for the safety and quality of clinical services
- accountability for the safety and quality of clinical services throughout the organisation to the governing entity
- effective clinical risk management systems
- strong cultural leadership including a culture of questioning and reflection.<sup>76</sup>

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<sup>72</sup> Refer to section 5.2.4.

<sup>73</sup> Department of Human Services 2009, *Victorian clinical governance policy framework, Enhancing clinical care, State Government of Victoria, Melbourne.*

<sup>74</sup> DLA Phillips Fox, 2009, *Clinical governance framework and toolkit, op. cit., p. 2.*

<sup>75</sup> Department of Human Services 2009, *Victorian clinical governance policy framework, op. cit.*

<sup>76</sup> DLA Phillips Fox 2009, *Clinical governance framework and toolkit, op. cit., p. 2.*



A formal and effective clinical governance framework is required to ensure continuous improvement in the safety and quality of care.

### 5.4.1 Clinical governance framework

A clinical governance framework for a health service and a GP organisation working in collaboration to provide a co-located AHGP clinic is outlined in Figure 1. This diagram draws on concepts developed by the Health Care Standards Unit of Keele University.<sup>77</sup>

The clinical governance framework for co-located AHGP clinics covers six key domains:

- Domain 1 – governance structures
- Domain 2 – purposes, roles and responsibilities
- Domain 3 – best practice systems for the delivery of quality clinical care
- Domain 4 – provider competence and performance
- Domain 5 – data and information to inform decisions at all levels of the organisation
- Domain 6 – risk management with a focus on the clinical interface.<sup>78</sup>

Appendix 4 contains a description of each domain of the clinical governance framework for co-located AHGP clinics.

### 5.4.2 Clinical governance toolkit

Health services and GP organisations providing a co-located AHGP clinic are to utilise the toolkit developed by DLA Phillips Fox to facilitate the implementation of the clinical governance framework outlined above.

The clinical governance toolkit for co-located AHGP clinics contains examples of:

- a formal written agreement between a health service and a GP organisation on the provision of after-hours primary medical care
- vision statements
- triage criteria
- patient information
- a disclaimer of liability clause for health services
- a GP information handbook
- checklists for
  - good governance
  - agreeing the purpose of the collaboration
  - assessing the risk of shared liability
  - identifying clinical risk management at the interface between the ED and co-located clinic
  - GP contractors
  - ‘professionalism’ of GPs
- useful references and websites.

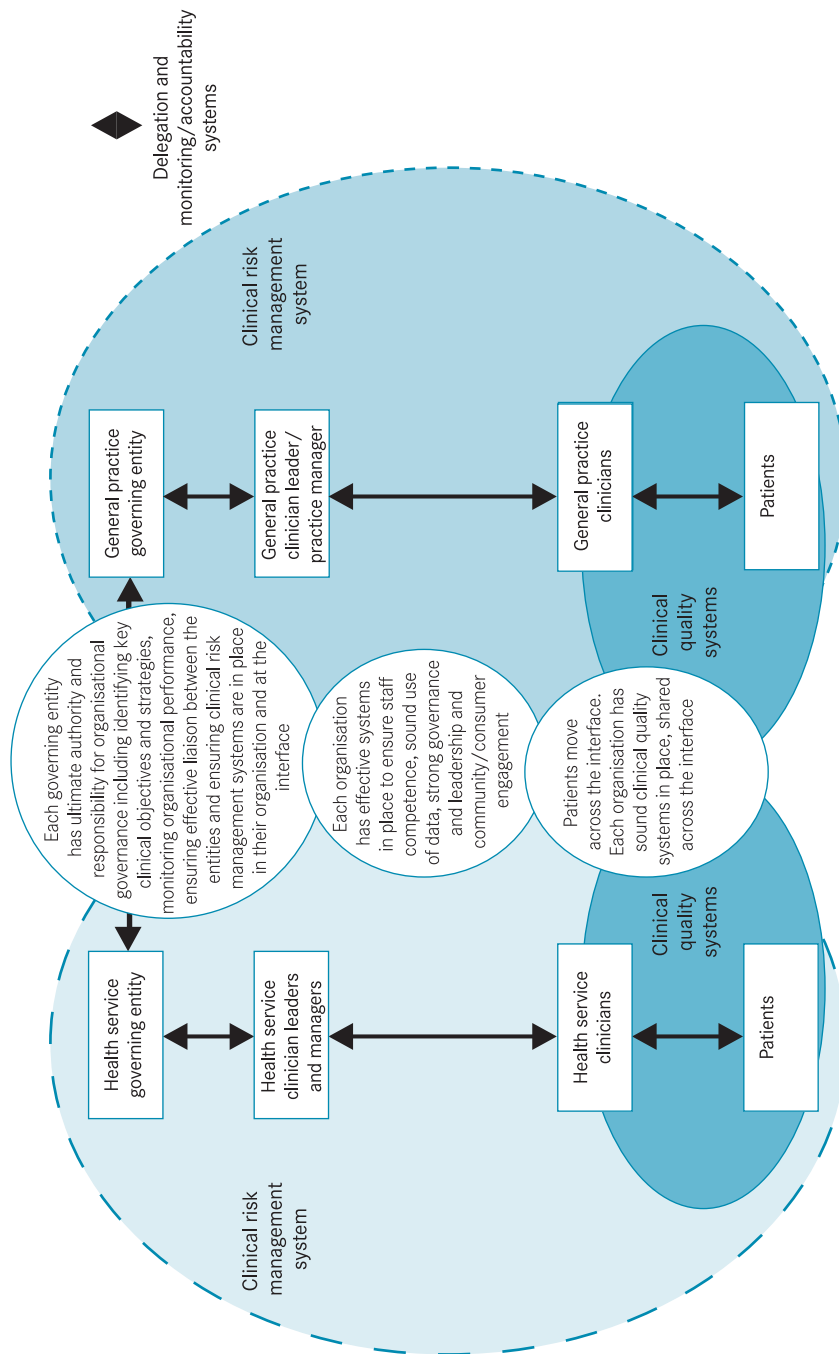
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<sup>77</sup> Health Care Standards Unit 2009, *The standards for better health: Improving board assurance*, viewed 8 February 2009, <[http://www.hcsu.org.uk/index.php?option=com\\_docman&task=doc\\_view&gid=634](http://www.hcsu.org.uk/index.php?option=com_docman&task=doc_view&gid=634)>.

<sup>78</sup> DLA Phillips Fox 2009, *Clinical governance framework and toolkit*, op. cit., p. 9.

The complete toolkit is available in the companion document developed by DLA Phillips Fox entitled *Clinical governance of co-located and well-located after-hours general practice services A framework and toolkit*.<sup>79</sup>

**Figure 1: A clinical governance framework for collaborating health services**



<sup>79</sup> See <[www.health.vic.gov.au/emergency](http://www.health.vic.gov.au/emergency)>.

## 5.5 Staffing of co-located clinics

Co-located AHGP clinics are to be staffed by GPs and appropriately experienced practice staff in accordance with the RACGP Standards<sup>80</sup> and the established code for the management and administration of medical practices.<sup>81</sup>

GPs are to be vocationally recognised or be vocationally registered and hold a Fellowship of the RACGP (FRACGP) or a Fellowship of the Australian College of Rural and Remote Medicine (FACRRM).<sup>82</sup> GPs must have a provider number that will enable them to access Medicare funding<sup>83</sup> at the co-located AHGP clinic.

In a co-located clinic where a significant number of GPs work part time, outside business hours, with limited interaction as a peer group, the co-located AHGP clinic is to ensure a GP clinical leader is appointed to:

- provide strong medical cultural leadership
- be a focus for communication with GPs and between the clinic and the ED
- take a lead role in clinical governance activities.

The clinic may be operated by a practice manager experienced in general practice to:

- ensure the service maintains the character of a community-based general practice
- facilitate effective management of multiple GPs and practice staff employed on a sessional basis
- ensure all facets of the clinic operations the clinic are in accordance with the RACGP Standards and legislative, regulatory and funding requirements
- build and maintain working relationships with local GPs and divisions of GP.

Non-medical staff involved in clinical care in the practice and administrative staff are to be appropriately trained for their role. Health services may provide nursing and administrative staff from the hospital ED to work in the co-located AHGP clinic. In these instances, training is to be provided to ED staff to ensure competency in the relevant aspects of general practice management and administration.

In recognition of GP workforce shortages in some areas<sup>84</sup> and the challenge of attracting staff to work outside business hours, co-located AHGP clinics, in conjunction with health services, GP divisions and local GPs, may utilise a range of strategies to secure an adequate GP workforce to staff the clinic, including:

- working with Victorian regional registered training providers and GPL services to provide placements in the co-located AHGP clinics and ED for provisional vocational GP registrars

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<sup>80</sup> RACGP 2005, *op. cit.*, Standard 3.2 Criterion 3.2.1–3.2.3.

<sup>81</sup> Royal Australian College of General Practice 2001, *A code of conduct for corporations involved in the provision of management and administrative services in medical centres in Australia*, RACGP, South Melbourne.

<sup>82</sup> Under the Health Insurance Act regulations vocationally registered GPs are eligible for a Medicare provider number. See: Australian General Practice Training 2009, *Guide for GP registrars*, Canberra, pp. 87–90.

<sup>83</sup> Vocationally registered GPs may access special Medicare item numbers and higher Medicare rebates. See <[www.racgp.org.au/curriculum](http://www.racgp.org.au/curriculum)>.

<sup>84</sup> There has been a decline in the available GP workforce in many areas of Australia in recent years. See: Australian College of Rural and Remote Medicine et al. 2009, *The future general practice education and training system: Discussion paper*, Brisbane.

undertaking an advanced specialist or rural training year (this arrangement would require consultant support from GP mentors in supervising practices and ED physicians)<sup>85</sup>

- formal arrangements between a local general practice and the co-located AHGP clinic under which the co-located clinic provides after-hours coverage for a GP practice that regularly rosters GPs to work in the clinic and participates in hospital professional development and quality and safety activities<sup>86</sup>
- a centralised system for coordinating staffing of after-hours services.

### 5.5.1 Professional development

Health services, in collaboration with co-located AHGP clinics, are to support professional development opportunities for GPs working in AHGP clinics by providing access to:

- relevant ED education programs
- shared clinical placements
- consultations with ED and other hospital physicians.

Co-located AHGP clinics, in conjunction with health services, the GPL service and local GP divisions, may establish clinical education and professional development programs on emergency medicine for GPs working in co-located clinics.

Programs are to form part of the RACGP quality assurance and continuing professional development<sup>87</sup> for GPs that involves a combination of educational activities and assessment and audit of practice, which is completed in rolling triennia. The educational programs are to attract appropriate continuing professional development recognition.

Consideration is to be given to the timing and scheduling of training sessions to maximise GPs' participation.

## 5.6 Performance monitoring

Health services, in conjunction with co-located AHGP clinics, are to establish effective systems to monitor the organisational performance of co-located AHGP clinics and health services in providing after-hours primary medical care.

The information and monitoring systems are to inform co-located AHGP clinics and health services about service performance, facilitate future planning and promote continuous quality improvement.

In a collaborative partnership where more than one organisation is responsible for providing a service, the Co-located AHGP Clinic Liaison Committee has a key role in monitoring and evaluating the performance of the service and reporting to the appropriate governing entities.

The Co-located AHGP Clinic Liaison Committee may monitor and evaluate the performance of the service utilising information collected through:

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<sup>85</sup> *Australian General Practice Training 2009, op. cit., pp. 1–12.*

<sup>86</sup> *Consideration will need to be given to the availability of GP cooperatives and deputising services in the hospital catchments area to ensure compliance with legislative requirements of the Trade Practices Act.*

<sup>87</sup> See <[www.racgp.org.au/QACPD](http://www.racgp.org.au/QACPD)>.

- the Victorian Emergency Minimum Dataset (VEMD), which records activity data and patient-level information<sup>88</sup>
- project progress reports prepared for the Commonwealth AHGP program that requires information on community needs, quality assurance, GP workforce and financial viability<sup>89</sup>
- Medicare information
- consumer and staff satisfaction surveys.

The clinical governance framework outlined in this document<sup>90</sup> outlines a range of indicators that may be used to measure and monitor the quality and performance of the clinical systems, particularly at the interface between the ED and the clinic.

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*88 VEMD is a client level electronic reporting system utilised in hospital EDs, which can provide information on ED presentations and consumers registered as an ED attendance who leave after advice to attend a GP clinic.*

*89 See <<http://www.health.gov.au/internet/main/publishing.nsf/Content/gpahp-lp>>.*

*90 Refer to Appendix 4 Domain 5.*

## Appendix 1: Advisory groups

### Emergency Access Reference Committee – Primary Care Subcommittee

<b>Chairperson</b>	
Mr Bill Newton	Chief Executive Officer, General Practice Victoria
<b>Members</b>	
Ms Sylvia Barry	Manager, Primary Health Integration, Primary Health Branch, Department of Health
Dr Simon Young	Director Emergency Department, Royal Children’s Hospital
Dr David Isaac	General Practice Liaison Service, St Vincent’s Health
Dr Sharon Monagle	Senior Medical Adviser, Primary Health Branch, Department of Health
Ms Ann Maree Keenan	Executive Director Ambulatory & Nursing Services, Austin Health
Dr Sue Hookey	Director, General Practice Liaison, Melbourne Health
Ms Ellen Wilson	Manager, HARP, PAC & Community Health, Bendigo Health Care Group
Dr Margaret Grigg	Assistant Director, Acute Health Service Program, Department of Health
Ms Sue O’Sullivan	Manager, Emergency Program, Access & Metropolitan Performance, Department of Health
<b>Secretariat</b>	
Ms Wendy Davis	Senior Project Officer, Emergency Program, Department of Health

## Co-located After-hours General Practice Clinics Working Group

<b>Chairpersons</b>	
Dr Margaret Grigg	Assistant Director, Acute Health Service Program, Department of Health
Ms Sue O’Sullivan	Manager, Emergency Program, Department of Health
<b>Members</b>	
Mr Bill Newton	Chief Executive Officer, General Practice Victoria
Dr Simon Young	Director Emergency Department, Royal Children’s Hospital
Mr Robert Burnham	Executive Director, Clinical Operations/Chief Nursing Officer, Northern Health
Mr Matt Kropman	ED Nurse Unit Manager, Northern Hospital
Dr Michael Howson	Practice Principal, Keilor Road Medical Centre
Prof. George Braitberg	Professor of Emergency Medicine, Southern Health
Ms Catherine Harmer	Manager, Policy and Strategy Unit, Statewide Quality, Department of Health
Mr Philip Bain	Chief Executive Officer, Northern Division of General Practice
Ms Barbara Repcan	Practice Manger, Eastern General Practice After-hours Clinic
Dr Wendy Fisher	General Practice Liaison Officer, Austin Health
Mr Stewart Potten	Chief Executive Officer, Royal Australian College of General Practice, Victorian Faculty
Dr Sharon Monagle	Senior Medical Adviser, Primary Health Branch, Department of Health
A/Prof. Graeme Thompson	Director, Emergency Department, Angliss Hospital.
<b>Secretariat</b>	
Ms Wendy Davis	Senior Project Officer, Emergency Program, Department of Health

## Appendix 2: Policy and program statements relevant to co-located after-hours general practice clinics

### State policies

The Victorian Government policies relevant to co-located AHGP clinics are as follows.

#### *Victoria: A better state of health*

The government's 2005 policy *Victoria: A better state of health*<sup>91</sup> outlines the overarching principles that provide a vision for health care in this state.

#### *Care in your community*

*Care in your community: A planning framework for integrated ambulatory care*<sup>92</sup> provides a vision for an integrated and person- and family-centred health system. It is about refocusing and investing in the best mix of hospital and community-based care services to better meet the needs of Victorians. It focuses on integrating the component parts of the system and reforming existing systems, structures and processes to support flexible service delivery and person-focused continuity of care.

#### *Better quality, better health care*

The Victorian Quality Council (VQC) was established in 2001 to foster quality and safety in Victorian health services. The council's framework *Better quality, better health care*<sup>93</sup> outlines the principles and practices necessary for effectively monitoring, managing and improving health services. The *Victorian clinical governance policy framework – Enhancing clinical care*<sup>94</sup> defines clinical governance and outlines the principles that support excellence and good governance of clinical care.

#### *Working with general practice*

The 2007 *Working with general practice: Department of Human Services position statement*<sup>95</sup> was developed with a vision of strengthening a collaborative interface between the then Department of Human Services (now the Department of Health), state-funded services and general practice, resulting in more integrated service delivery and better health outcomes for Victorians.

### National policies and programs

The Commonwealth Government has predominant funding responsibility for the GP sector through fee-for-service payments under Medicare. National health policy directions for primary health care are therefore important for GP and hospital integration.

### National Health and Hospitals Reform Commission

The National Health and Hospitals Reform Commission was established in by the Council of Australian Governments (COAG) in late 2007 to provide advice on performance benchmarks and practical reforms to the Australian health system.<sup>96</sup>

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<sup>91</sup> Department of Human Services 2005, *Victoria: A better state of health*, State Government of Victoria, Melbourne.

<sup>92</sup> Department of Human Services 2006, *Care in your community: A planning framework for integrated ambulatory care*, State Government of Victoria, Melbourne.

<sup>93</sup> Department of Human Services and Victorian Quality Council, *Better quality better health care*, op. cit.

<sup>94</sup> Department of Human Services 2008, *Victorian clinical governance policy framework*, op. cit.

<sup>95</sup> Department of Human Services 2007, *Working with general practice: Department of Human Services position statement*, State Government of Victoria, Melbourne, p. 3.

<sup>96</sup> See <[www.nhhrc.org.au](http://www.nhhrc.org.au)>.



The commission released *A healthier future for all Australians, Final report*<sup>97</sup> in June 2009, which articulated a vision of a sustainable, high-quality, responsive health system for all Australians now and into the future.

Three reform goals were identified:

- tackling major access and equity issues that affect health outcomes for people now
- redesigning the health system so that it is better positioned to respond to emerging challenges
- creating an agile and self-improving health system for the long term.

The transformative actions proposed by the commission included strengthening and integrating primary health care to create a platform for comprehensive care that brings together health promotion, early detection and intervention and the management of people with acute and ongoing conditions.

### General Practice After Hours Program

The Commonwealth General Practice After-Hours Program (GPAHP) was formed by merging the former RTC: IAHGPs and the After Hours Primary Medical Care programs.<sup>98</sup> The policy goal of the GPAHP is to ensure that as many people as possible have access to quality after-hours GP services through developing of new services and maintaining and enhancing existing services. Key program requirements are that the after-hour's services will have the support of the local GP community and do not create unfair competition with existing local services.

### Royal Australian College of General Practitioners Standards

The Royal Australian College of General Practitioners (RACGP) is a professional organisation that focuses on the safety and quality of general practice. RACGP have established Standards for general practices that reflect the essential processes, systems and structures needed to provide comprehensive primary health care to the general practice patient population and, as such, they are also relevant to services that provide this care on behalf of a practice. The Standards apply to services that provide comprehensive care to general practice patients outside the normal opening hours of the patient's practice.

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<sup>97</sup> *National Health and Hospitals Reform Commission 2009, A healthier future for all Australians, Final report, Canberra.*

<sup>98</sup> *Department of Health and Ageing 2008–09, General practice after hours program, op. cit., pp. 6–7.*

## **Appendix 3: Sample formal agreement between a health service and an organisation providing a co-located after-hours general practice clinic**

### **Co-located Clinic Agreement**

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**Definitions and interpretation**

Definitions

Interpretation

**Execution and date**

## Parties

**Health Service** of address (**the Health Service**)

**Clinic** of address (**the Clinic**)

## Background

The Health Service is a public hospital established pursuant to the Health Services Act 1988 (Victoria). The Clinic conducts a general practice of medicine at premises which are co-located with the Health Service.

The Health Service prompts patients to consider treatment at the Clinic when they attend the emergency department of the Health Service and:

- they are assessed as not requiring emergency care
- they are unwilling or unable to wait for care from the Health Service.

This Agreement records the arrangements between these co-located Organisations.

## Operative provisions

### Vision and purpose

#### Co-located clinic

- 1.1 The Organisations have agreed to work together as separate but co-located bodies, as specialists in their area, to improve the delivery of targeted health services to members of the public seeking health care in a circumstance of accident or emergency with the purpose of improving the patient experience and rationalising scarce resources.

#### Strategic plan

- 1.2 The Organisations must develop a strategic plan for their co-location through the Liaison Committee. They must establish review points for reconsideration of the strategic plan by reference to time or other factors.
- 1.3 The Liaison Committee must consider whether the operation of their co-location is meeting the needs of the Organisations, and fulfilling the vision and purpose expressed in this document.

### Governance structures

#### Parties to ensure understanding

- 1.4 Each Organisation must ensure that the other understands its legal structure.
- 1.5 The Clinic must give the Health Service a copy of its constituent documents and details of all owners and managers. The Health Service must ensure that the Clinic is aware of its legal and organisational structure. Both Organisations must notify the other of changes.

## Liaison Committee

- 1.6 The Organisations must establish a Liaison Committee with representatives from both of them. They must give their representatives adequate delegated authority to ensure that meetings of the Liaison Committee are effective.

## Commitment to work together

- 1.7 Through the Liaison Committee, the Organisations must work together to improve the cooperation between their staff, to enhance patient safety, to improve communication, to improve the patient experience, to reduce inefficiency and to reduce waste.

## First meeting

- 1.8 At the first meeting of the Liaison Committee, its members must establish processes for the efficient functioning of the Liaison Committee. These should include:
  - 1.8.1 who will chair and organise meetings
  - 1.8.2 the location, date and frequency of meetings
  - 1.8.3 the standard agenda for meetings
  - 1.8.4 the process by which extraordinary items are brought to the Committee
  - 1.8.5 voting processes for the Committee
  - 1.8.6 arrangements in the absence of members
  - 1.8.7 communication of resolutions of the Committee.

## Not separate legal entity

- 1.9 The Liaison Committee will not be a separate legal entity. It will be a mechanism for collaboration and communication between the two Organisations.

## Clinic fails to participate etc

- 1.10 If either of the Organisations:
  - 1.10.1 fails to participate in the Liaison Committee in a constructive way
  - 1.10.2 consistently breaches a non-material obligation in this document, or
  - 1.10.3 breaches a material obligation in this document, thenin any of these cases, the other Organisation may give the first a Show Cause Notice.

## Show Cause Notice

- 1.11 If one Organisation gives the other a Show Cause Notice, the other must provide the first with a reasonable explanation of the behaviour complained of in the Notice, or some reasonable assurance that it will not reoccur. If the first Organisation is dissatisfied with the explanation or assurance, it may initiate the dispute resolution provisions in this document.

## Protocols

- 1.12 The Organisations must develop written protocols to record their practical, recurrent requirements of one another. They should do so through the Liaison Committee.

1.13 The protocols are to be amended on the basis of experience. Amendments should be promulgated generally to ensure a clear understanding of roles and responsibilities.

### Communication generally

1.14 In addition to the Liaison Committee, both Organisations must appoint an individual (by role or by person) to enable simple communication between them. Each Organisation must ensure that the other is kept informed of arrangements during periods of absence, and any change in personnel.

## Patients

### Organisations must identify referred patients

1.15 Both Organisations must establish procedures to identify when a patient attends one of them for treatment of a condition having just attended the other for the same condition.

### Cross-notification

#### Organisations to obtain consent

1.16 Subject to any restrictions imposed by the law, each Organisation must seek the consent of a patient to notify the other Organisation of the patient's particulars where the patient has been referred in the terms of clause 4.1. Those particulars should include:

- 1.16.1 name, address and contact details of the patient
- 1.16.2 the time of attending the second Organisation
- 1.16.3 an epitome of the diagnosis of the patient.

#### Clinic to warn

1.17 If a referred patient (in accordance with clause 4.1) attends the Clinic and is diagnosed by the Clinic as having a medical emergency or condition requiring specialist expertise beyond that of the treating medical staff in the Clinic:

- 1.17.1 subject to the law, the Clinic must notify the designated person in the Health Service of the diagnosis
- 1.17.2 the Clinic must advise the patient that they must be treated in the emergency department of the Health Service
- 1.17.3 the Clinic must coordinate the treatment of the patient with the Health Service.

## Services

### Defining the scope of services for the Clinic

1.18 Through the Liaison Committee, the Organisations must agree upon the scope of services that can be provided by the Clinic, taking into account the skills and experience of its medical staff, hours of operation, resources available to the medical staff and also their preferences.

1.19 As part of its ongoing review of the relationship, the Liaison Committee must review the Clinic's scope of services on a regular basis.

## Defining the scope of services for the health service

1.20 Through the Liaison Committee, the Health Service must keep the Clinic reasonably informed in relation to the collective scope of practice of its medical staff.

## Responsibility for clinical issues

### Organisations must agree

1.21 Through the Liaison Committee, the Organisations must discuss and agree upon the following:

- 1.21.1 Whether the Health Service will make any equipment available for use by the Clinic and, if so, on what basis. In particular, the Organisations must agree upon any protocols which are necessary for the use of equipment.
- 1.21.2 Access to and use of sterilising equipment by the Clinic.
- 1.21.3 The form and content of medical records to be used by the Clinic, where those records are to be stored, and whether and on what basis the Clinic could have access to any of the medical records of the Health Service. The Organisations must also agree upon the protocols in relation to the completion of medical records by the Clinic.
- 1.21.4 The development of protocols and follow-up in relation to those patients who attend the Clinic and are found to have abnormal pathology or imaging.
- 1.21.5 The development of protocols for communication with the usual general practitioner of a patient who attends the Clinic.
- 1.21.6 The development of protocols for participation in shared clinical governance activities.

## Standards

### Organisations to maintain standards

- 1.22 Through the Liaison Committee, the Organisations must create processes that are intended to achieve comparable and complementary standards of hygiene and infection control.
- 1.23 As the accepted industry standards change over time, the Liaison Committee must ensure those standards are reflected in the practices of both Organisations.

### Skills audit

1.24 On or about the commencement of this Agreement the Clinic must undertake an audit of the skills and experience of its medical staff. The Clinic must inform the Health Service of the results of that audit through the Liaison Committee.

### Credentials and scope of practice

- 1.25 The Clinic must develop processes of assessment intended to ensure both the technical competence and consistent performance of all medical staff who work in the Clinic. In particular:
  - 1.25.1 Through the Liaison Committee, the Clinic must develop, adopt and implement defined standards for credentialing and for scope of practice.
  - 1.25.2 The Clinic must establish processes that ensure all medical staff are reviewed against those standards.



- 1.25.3 If any medical staff in the Clinic undertake procedural general practice, in consultation with the Health Service, the Clinic must develop specific requirements for credentialing and scope of practice.
  - 1.25.4 The Clinic must ensure that medical staff maintain vocational registration.
  - 1.25.5 The Clinic must ensure that the terms of engagement of medical staff place limitations on them to perform professional services within the Clinic within their scope of practice.
- 1.26 The Health Service must give reasonable assistance to the Clinic in the development of an effective contract of engagement of its medical staff.

### **Triage**

- 1.27 The Health Service must ensure the medical staff engaged in the triage of patients are appropriately trained. In addition, the Health Service must create a system to review the engagement with patients who continue their treatment with the Clinic, having first initiated treatment with the emergency department of the Health Service.

## **Material change**

### **Health Service to be notified**

- 1.28 The Clinic must notify the Health Service of any material change in relation to each of the following:
- 1.28.1 the hours of operation of the Clinic
  - 1.28.2 the service capacity of the Clinic
  - 1.28.3 the safety of the Clinic.

## **Obligation to keep fully informed**

### **Health Service to be kept informed**

- 1.29 The Organisations must keep one another informed of all material facts, matters and circumstances that have (or could have) a material effect on their capacity to deliver medical services to the standards of this Agreement.

### **Complaints**

- 1.30 The Organisations must advise one another of any complaints made to them by patients who have sequentially attended both the Clinic and the Health Service, regardless of the order of doing so.

### **Malpractice claims**

- 1.31 The Organisations must advise one another of any medical malpractice claims made by patients who have sequentially attended both the Clinic and the Health Service, regardless of the order of doing so.

## Insurance

### Clinic to maintain insurance

- 1.32 The Clinic must ensure each of its medical staff is insured against medical malpractice claims by an established insurer, subject only to traditional exclusions, for an amount considered sufficient by the insurer for Health Service from time to time.
- 1.33 The Clinic must provide the Health Service with evidence of its medical malpractice insurance when requested to do so.

## Lease or licence

### Health Service to provide

- 1.34 The Health Service must grant the Clinic a right to occupy that area which the Health Service has set aside for the conduct of a co-located general practice clinic. If the Health Service does not own the area (for instance, if it is reserved Crown land), it must do what is necessary to procure that right of occupancy.

### Formal document to be prepared

- 1.35 The right of occupancy must be recorded in a formal document appropriate to the area. The Health Service will arrange for the preparation of the document. Both parties must bear their own costs in relation to the document.

### Particulars of document

- 1.36 Unless the parties agree in writing to the contrary, the occupancy document for the Clinic will be in standard form (appropriate to the land and other considerations) except for the following:
- 1.36.1 The term of the document will be five years with an option for a further five years exercisable at the option of the Clinic.
  - 1.36.2 Subject to clause 12.4, the rent will be nominal.
  - 1.36.3 There will be no requirement for a personal guarantee if the Clinic is a corporation.
  - 1.36.4 The document will record that the Clinic must pay its reasonable share of occupancy costs. Examples of these costs are power, medical gases, air conditioning, water, building maintenance, cleaning, waste removal and laundry.
  - 1.36.5 In addition to the standard provisions concerning breach of covenant and non-payment of rent, termination of the occupancy will also happen if this Agreement is terminated according to its terms.

### Fit-out and alterations

- 1.37 If the Clinic requires fit-out or alteration of the co-located facility, or services, in any way to accommodate the Clinic (for instance, partitioning, air conditioning alterations, plumbing), then the Health Service will be entitled to recover that capital cost over the first term of the lease as rent. The Health Service can also recover as rent a market return on the money paid for this work.

## Service agreement

### Clinic must enter into service agreement

- 1.38 The Health Service will prepare, and the Clinic must execute, a service agreement for providing (among other things) housekeeping, maintenance and IT services by the Health Service. The service agreement is entitled to charge the Clinic a fee for all such services on a full cost recovery basis.
- 1.39 The Clinic must enter into a service agreement on or before the time that it first occupies its co-located area.
- 1.40 The service agreement will end when the Clinic ceases to occupy its co-located area.

## Training

### Clinic to participate

- 1.41 The Clinic must ensure that its medical staff participate in the training made available to the medical staff of the Health Service if that training is relevant to their activities.

### Junior medical staff

- 1.42 If junior medical staff engaged by the Health Service wish to gain experience in general practice, the Clinic must give reasonable assistance to facilitate a program for that purpose.

## Safety and quality

### Occupational health and safety

- 1.43 The Clinic must establish guidelines for occupational health and safety that mirror those of the Health Service at all times. The Clinic must ensure its staff satisfy those requirements at all times. The Clinic must submit details of its management systems, plans and programs relating to occupational health and safety to the chief executive officer of the Health Service at the commencement of this Agreement, and also when requested to do so.

### Development of a quality framework

- 1.44 The Organisations must agree upon who is responsible for the design, implementation and monitoring of a system of quality clinical care in each of their environments; the Health Service in relation to triage and also patients referred from the Clinic, and the Clinic in relation to patients from the emergency department of the Health Service.
- 1.45 Each Organisation must then implement management processes designed to ensure every person engaged by them executes the system. That system should address the dimensions of quality in the publication from the Victorian Quality Council entitled *Better quality, better health care: A safety and quality improvement framework for Victorian health service* and also the publication from the RACGP entitled *A quality framework for Australian general practice*.

## Accreditation

### Accreditation of the Clinic

- The Clinic must be or become an accredited general practice clinic formally accredited against the *RACGP Standards for General Practices* (3rd edition).
- The Clinic must seek formal accreditation through one of the following accreditation organisations:
  - Australian General Practice Accreditation Limited
  - Quality Practice Accreditation Limited (GPA Accreditation plus).

### Accreditation of the Health Service

- The Health Service must be or become accredited through one of the following accreditation bodies:
  - The Australian Council on Healthcare Standards' Evaluation and Quality Improvement Program (ACHS Equip)
  - The International Organisation for Standardisation's Quality Management System 9000 (ISO 9002)
  - Quality Improvement Council's Health and Community Services Standards (QIC).

### Obligations associated with accreditation

- Both Organisations must ensure that they:
  - meet and maintain the standards required for accreditation
  - follow the processes required for accreditation
  - renew their accreditation in a timely manner.

## Resolution of disputes

### Disputes covered

1.46 The procedures set out below must be followed in relation to the resolution of a dispute concerning this Agreement, its subject matter or the rights or liabilities of the parties to this Agreement.

### Notice in writing

1.47 If a dispute of the type referred to in clause 16.1 arises, either party may at any time give written notice to the other party. The written notice must adequately specify the nature of the dispute.

### Meeting to resolve dispute

1.48 On receipt of a notice delivered in accordance with clause 16.2, the nominated representatives of both parties must meet within five business days of the notice and, in good faith and acting reasonably, do their best to resolve the dispute quickly through negotiation.

## Mediation

- 1.49 If the dispute has not been resolved within seven days from the meeting under clause 16.3 or such later date as the parties may agree, the dispute must be referred to mediation.
- 1.50 If the parties do not agree on a mediator, then the mediator must be appointed by the President of the Law Institute of Victoria.
- 1.51 Unless the parties agree otherwise, the mediator's fee and any other costs of the mediation itself (such as for venue hire or refreshments) must be shared equally between the parties, but the parties must each pay their own costs of preparing for and participating in the mediation (such as for travel and legal representation).

## Implementation of agreement reached through negotiation or mediation

- 1.52 The parties must do whatever is reasonably necessary to put into effect any negotiated or mediated agreement or other resolution of the dispute.

## Litigation

- 1.53 If the dispute is not resolved within either three months from the date of a notice delivered in accordance with clause 16.2, or any other period agreed by the parties, then either party is free to pursue its rights at law.

## Rights and obligations during a dispute

- 1.54 Despite the existence of a dispute, each party must continue to perform its obligations, and remains entitled to any benefits, under this Agreement.

## Interlocutory relief and right to terminate

- 1.55 This clause 16 does not restrict or limit the right of either party to obtain interlocutory relief, or to immediately terminate this Agreement where this Agreement provides such a right.

## Notices

### Giving notices

- 1.56 Any notice or communication given to a party under this Agreement is only given if it is in writing and sent in one of the following ways:
- 1.56.1 delivered or posted to that party at its address and marked for the attention of the relevant department or officer (if any) set out below
  - 1.56.2 faxed to that party at its fax number and marked for the attention of the relevant department or officer (if any) set out below.

### The Health Service

Name: Health Service  
Address: Address  
Fax number: [Fax number]  
Attention: the Chief Executive Officer

**The Clinic**

Name: The Clinic  
 Address: Address  
 Fax number: [Fax number]  
 Attention: The Manager

**Change of address or fax number**

1.57 If a party gives the other party three business days' notice of a change of its address or fax number, any notice or communication is only given by that other party if it is delivered, posted or faxed to the latest address or fax number.

**Time notice is given**

1.58 Any notice or communication is to be treated as given at the following time:

- 1.58.1 if it is delivered, when it is left at the relevant address
- 1.58.2 if it is sent by post, two (or, in the case of a notice or communication posted to another country, nine) business days after it is posted
- 1.58.3 if it is sent by fax, as soon as the sender receives from the sender's fax machine a report of an error free transmission to the correct fax number.

1.59 However, if any notice or communication is given, on a day that is not a business day or after 5pm on a business day, in the place of the party to whom it is sent it is to be treated as having been given at the beginning of the next business day.

**Miscellaneous****Approvals and consents**

1.60 Unless this Agreement expressly provides otherwise, a party may give or withhold an approval or consent in that party's absolute discretion and subject to any conditions determined by the party. A party is not obliged to give its reasons for giving or withholding a consent or approval or for giving a consent or approval subject to conditions.

1.61 Where this Agreement refers to a matter being to the 'satisfaction' of a party, this means to the satisfaction of that party in its absolute discretion.

**Assignments and transfers**

1.62 A party must not assign or transfer any of its rights or obligations under this Agreement without the prior written consent of each of the other parties.

**Costs**

1.63 Except as otherwise set out in this Agreement, each party must pay its own costs and expenses for preparing, negotiating, executing and completing this Agreement and any document related to this Agreement.

### Entire agreement

1.64 This Agreement contains everything the parties have agreed in relation to the subject matter it deals with. No party can rely on an earlier written document or anything said or done by or on behalf of another party before this Agreement was executed.

### Execution of separate documents

1.65 This Agreement is properly executed if each party executes either this document or an identical document. In the latter case, this Agreement takes effect when the separately executed documents are exchanged between the parties.

### Further acts

1.66 Each party must at its own expense promptly execute all documents and do or use reasonable endeavours to cause a third party to do all things that another party from time to time may reasonably request in order to give effect to, perfect or complete this Agreement and all transactions incidental to it.

### Governing law and jurisdiction

1.67 This Agreement is governed by the law of Victoria. The parties submit to the non-exclusive jurisdiction of its courts and courts of appeal from them. The parties will not object to the exercise of jurisdiction by those courts on any basis.

### Joint and individual liability and benefits

1.68 Except as otherwise set out in this Agreement, any covenant, agreement, representation or warranty under this Agreement by two or more persons binds them jointly and each of them individually, and any benefit in favour of two or more persons is for the benefit of them jointly and each of them individually.

### Severability

1.69 Each provision of this Agreement is individually severable. If any provision is or becomes illegal, unenforceable or invalid in any jurisdiction it is to be treated as being severed from this Agreement in the relevant jurisdiction, but the rest of this Agreement will not be affected. The legality, validity and enforceability of the provision in any other jurisdiction will not be affected.

### Variation

1.70 No variation of this Agreement will be of any force or effect unless it is in writing and signed by each party to this Agreement.

### Waivers

1.71 A waiver of any right, power or remedy under this Agreement must be in writing signed by the party granting it. A waiver only affects the particular obligation or breach for which it is given. It is not an implied waiver of any other obligation or breach or an implied waiver of that obligation or breach on any other occasion.

1.72 The fact that a party fails to do, or delays in doing, something the party is entitled to do under this Agreement does not amount to a waiver.

## Definitions and interpretation

### Definitions

1.73 In this Agreement the following definitions apply:

**Agreement** means this document and the obligations to which the parties have agreed which are recorded in it.

**Clinic** means the second named party to this Agreement.

**Health Service** means the first named party to this Agreement.

**Liaison Committee** means the committee representing both Organisations brought into existence in accordance with clause 3.

**Organisations** means both the Clinic and the Health Service. Organisation means one of them.

**Show Cause Notice** means a notice pursuant to clause 3.6 from one Organisation to another.

### Interpretation

1.74 In the interpretation of this Agreement, the following provisions apply unless the context otherwise requires:

1.74.1 Headings are inserted for convenience only and do not affect the interpretation of this Agreement.

1.74.2 A reference in this Agreement to a business day means a day other than a Saturday or Sunday on which banks are open for business generally in Melbourne, Victoria.

1.74.3 If the day on which any act, matter or thing is to be done under this Agreement is not a business day, the act, matter or thing must be done on the next business day.

1.74.4 A reference in this Agreement to 'dollars' or '\$' means Australian dollars and all amounts payable under this Agreement are payable in Australian dollars.

1.74.5 A reference in this Agreement to any law, legislation or legislative provision includes any statutory modification, amendment or re-enactment, and any subordinate legislation or regulations issued under that legislation or legislative provision.

1.74.6 A reference in this Agreement to any document or Agreement is to that document or Agreement as amended, novated, supplemented or replaced.

1.74.7 A reference to a clause, part, schedule or attachment is a reference to a clause, part, schedule or attachment of or to this Agreement.

1.74.8 An expression importing a natural person includes any company, trust, partnership, joint venture, association, body corporate or governmental agency.

1.74.9 Where a word or phrase is given a defined meaning, another part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning.

1.74.10 A word that indicates the singular also indicates the plural, a word that indicates the plural also indicates the singular, and a reference to any gender also indicates the other genders.

1.74.11 A reference to the word 'include' or 'including' is to be interpreted without limitation.

1.74.12 Any schedules and attachments form part of this Agreement.

### Execution and date

Executed as an agreement.

Date:



## Appendix 4: Domains of the clinical governance framework for co-located after-hours clinics

The clinical governance framework for co-located AHGP clinics covers six key domains:

- Domain 1 – governance structures
- Domain 2 – purposes, roles and responsibilities
- Domain 3 – best practice systems for the delivery of quality clinical care
- Domain 4 – provider competence and performance
- Domain 5 – data and information to inform decisions at all levels of the organisation
- Domain 6 – risk management with a focus on the clinical interface.<sup>99</sup>

### Domain 1 – Governance structures

The governing entity of a health care organisation has ultimate responsibility and authority to ensure clinical systems are well designed and perform effectively. In a collaborative partnership this is a joint responsibility that is based on a clear delineation of separate and joint duties and responsibilities.<sup>100</sup>

Health services and organisations governing co-located AHGP clinics are to clearly identify which organisation is responsible for each aspect of the AHGP service and which are delivered at the interface between two providers. Effective clinical systems are to be developed on the basis of these allocations.

Health services and organisations governing co-located clinics are to utilise the Co-located AHGP Clinic Liaison Committee<sup>101</sup> to support the delivery of quality services. The committee's clinical governance roles would include:

- overseeing the allocation of clinical roles, delegations and responsibilities
- overseeing the development, implementation and monitoring of an agreed quality framework and quality systems
- considering and advising on the implications for safety and quality of the strategic directions established for the clinic
- considering and analysing clinical governance risks and opportunities and advising on their management
- advising on the causes and remedies for any quality risks or opportunities arising at the interface between the organisations
- monitoring an agreed set of information about the adequacy of clinical systems and the quality of clinical services (with a focus on interface) and advising both organisations on the implications of the assessed performance
- enhancing patient safety and the patient experience
- establishing a consolidated policy and procedures manual to be maintained within each organisation.

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<sup>99</sup> DLA Phillips Fox 2009, *Clinical governance framework and toolkit*, op. cit., p. 9.

<sup>100</sup> Refer to section 5.2.6.

<sup>101</sup> Refer to section 5.2.4.

## Domain 2 – Purposes, roles and responsibilities

Consistent with the principles of consumer focus and evidence-based clinical care, once health services and GP organisations have clearly identified which organisation is responsible for each aspect of the service, responsibilities are to be delegated from the respective governing entities throughout their organisations to those who deliver services to consumers.

The Co-located AHGP Liaison Committee is to oversee the process of allocating roles and responsibilities at the organisational level.<sup>102</sup>

Health services and the organisations governing co-located AHGP clinics are to articulate organisational roles, delegations and responsibilities in areas such as:

- equipment and consumables including sterilising equipment
- consumer information and medical records
- medication imprest and pharmacy services
- follow-up of investigative tests and results
- notifications and information exchange between the co-located clinic and other general practices
- care pathways and screening criteria.<sup>103</sup>

At a management level, health services and GP organisations are to ensure a GP practice manager and GP clinical leader are appointed to administer and manage the co-located AHGP clinic and its clinicians.<sup>104</sup>

The GP clinical leader is to take a lead role in clinical governance activities including:

- participation in setting the safety and quality agenda and leading its implementation
- establishing clinical practice guidelines
- designing clinical systems including systems for following up investigative test results and referrals to other services
- advising on physical facilities and equipment
- determining resource allocation priorities
- ensuring key clinical governance controls for medical practitioners are in place, including an effective credentialing system, a system for defining the scope of practice for GPs
- ensuring GP participation in ED education programs.

Individual clinicians in the health service and co-located clinic are to support the delivery of quality services by undertaking the responsibilities for:

- delivering care and services in accordance with agreed policies and procedures
- participating in the development, implementation and evaluation of quality and safety plans, systems and activities
- reporting safety and quality issues and adverse events and participating in the development of solutions

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<sup>102</sup> Refer to section 5.2.6.

<sup>103</sup> DLA Phillips Fox 2009, *Clinical governance framework and toolkit*, op. cit., pp. 21–22.

<sup>104</sup> Refer to section 5.3 for description of the roles and responsibilities of these staff.

- adhering to policies and procedures for preventing, reporting and disclosing adverse events
- participating in activities that identify and address areas for improvement from a patient and staff perspective
- participating in a team approach to patient care, quality improvement and problem solving.

### Domain 3 – Systems to deliver quality clinical care

Health services, in conjunction with organisations governing co-located AHGP clinics, are to establish an agreed quality framework<sup>105</sup> and then design, implement and monitor quality systems to ensure high-quality clinical care. The individual and joint roles and responsibilities of the respective organisations for the quality systems are to be clearly articulated. The Co-located AHGP Clinic Liaison Committee is to oversee these key clinical governance activities.

The agreed quality framework, the quality systems and associated roles and responsibilities are to be incorporated into the formal written agreement established between health services and organisations providing co-located clinics.

### Domain 4 – Provider competence and performance

Health services in conjunction with the organisations governing co-located AHGP clinics are to establish systems for:

- verifying clinician credentials<sup>106</sup>
- ensuring clinicians work within the agreed scope of practice established for the co-located AHGP clinic<sup>107</sup>
- monitoring clinician performance.

### Domain 5 – Data and information

Health services, in conjunction with co-located AHGP clinics, are to establish a performance measurement and monitoring system in accordance with the agreed quality framework.

Health services and general practice share the same six dimensions of quality: safety, effectiveness, appropriateness, efficiency, access and acceptability.<sup>108</sup> Indicators that may be used to measure and monitor the quality and performance of the service, particularly at the interface between the ED and the clinic, include:

- frequency of reported adverse events (safety)

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*105 Health services and the organisations governing co-located AHGP clinics may utilise the frameworks developed by the Victorian Quality Council and the RACGP. Refer to: Department of Human Services and Victorian Quality Council 2003, Better quality better health care: A safety and quality improvement framework for Victorian health services, Melbourne and Booth B, Portelli R. and Snowdon T. 2005, A quality framework for Australian general practice, RACGP, Melbourne.*

*106 Department of Human Services 2007, Credentialing and defining scope of clinical practice in Victorian health services, State Government of Victoria, Melbourne.*

*107 Refer to section 4.2.*

*108 Department of Human Services 2008, Background paper: Clinical governance for providing after-hours general practice services for consumers presenting to hospital emergency departments, (unpublished), Melbourne, pp. 7–8.*

- frequency of repeat visits to the ED with an unresolved complaint (effectiveness)
- frequency of referrals back to the ED because of inappropriate triage to the co-located AHGP clinic
- proportion of PCT patients eligible for referral to the co-located AHGP clinic but not referred (appropriateness)
- average patient attendances per hour or session (efficiency)
- waiting times (access)
- results of patient satisfaction surveys
- frequency and type of complaints and compliments (acceptability).

Where co-located AHGP clinics are provided through a collaborative partnership, health services and the organisations governing the clinic health services are to clearly identify which organisation is responsible for monitoring the adequacy and performance of clinical systems. These decisions are to be made in terms of the overall governance, legal and clinical responsibilities stated in the formal written agreement established between health services and organisations providing co-located clinics.<sup>109</sup>

Accreditation is a useful independent mechanism for verifying that an organisation has acceptable clinical and management systems in place and a culture of continuous improvement. Co-located clinics, in conjunction with their health services, are to work towards accreditation with the Royal Australian College of General Practice as standards for special purpose services<sup>110</sup> are developed.

## Domain 6 – Clinical risk management

Health services, in conjunction with the organisations governing co-located AHGP clinics, are to establish a clinical risk management system that enables retrospective analysis of adverse events and promotes the safe design of clinical systems and support mechanisms. A clinical risk management framework for a health service and a GP organisation working in collaboration to provide a co-located AHGP clinic is outlined in Figure 2.

The Co-located AHGP Liaison Committee is to oversee the development and implementation of a shared risk management system.<sup>111</sup>

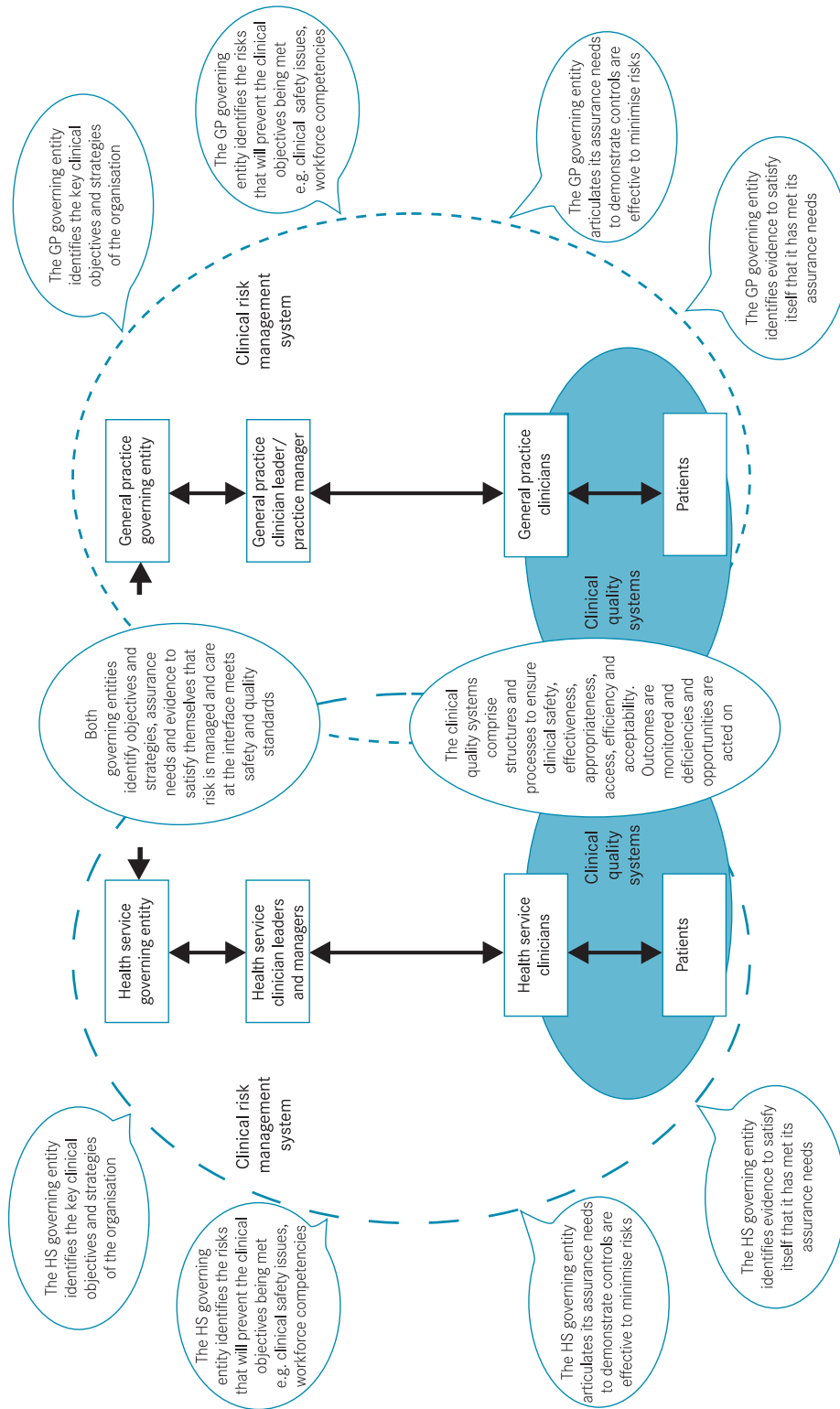
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<sup>109</sup> See <[www.health.vic.gov.au/emergency](http://www.health.vic.gov.au/emergency)>.

<sup>110</sup> *The current RACGP Standards require continuity of care as distinguished by two core elements, care over time and the focus on individual patients. As AHGP practices are unable to meet these requirements they can be considered as special purpose services. Appropriate accreditation standards are yet to be developed for such services.*

<sup>111</sup> Refer to section 5.2.

Figure 2: A clinical risk management framework for collaborating health services



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