



**World Class Accredited After Hours Primary Medical Care**



### MISSION STATEMENT

NAMDS is the peak body representing after-hours medical deputising services in Australia and seeks to facilitate and encourage high standards of after-hours primary medical care.

NAMDS develops and negotiates definitions and standards for medical deputising in Australia with Government, the Royal Australian College of General Practitioners and accreditation bodies to the betterment of patients, subscribing GPs and members.

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## Providing World Class Accredited After Hours Primary Medical Care

### WELCOME TO NAMDS

NAMDS is an association of member services who provide after hours care to over 17,500,000 Australians during the Commonwealth defined after hours period.

NAMDS services provide medical deputising to an estimated 9000 FTE GPs or around the same number as GP members of the AMA in Australia. The provision, integration and quality of after hours GP care is of increasing significance to Government, the profession and the community.

After Hours medical services are an extremely important feature of the Australian health care system. They ensure around the clock availability of quality medical care, including to the most vulnerable members of our community.

Medical Deputising plays a critical and growing role within the after hours system, delivering high quality

care when it is needed most. In particular, MDS divert many patients who would otherwise (often unnecessarily) attend an Emergency Department or call an ambulance.

Medical Deputising plays a key role in offsetting the declining level of home visiting by GPs and is primarily focused on treating patients in vulnerable categories such as children under 16 and elderly people including residents of aged care facilities.

Significantly, Medical Deputising also offers the highest level of continuity of care with the patient's GP through patient reports and the capacity to accommodate special patient instructions.

IN THE 2014 FINANCIAL YEAR NAMDS MEMBERS PROVIDED 1,052,549 EPISODES OF SERVICE, WITH MOST SERVICES PROVIDED IN RESIDENTIAL SETTINGS, WITH AROUND ONE-FIFTH OF SERVICES PROVIDED IN AGED CARE FACILITIES.

IN THE MAJORITY OF CASES (98%) THE PATIENT WAS CARED FOR AT HOME, 2% OF VISITS RESULTED IN A HOSPITAL REFERRAL AND LESS THAN 1% OF VISITS LED TO A NON-HOSPITAL REFERRAL.

15% OF VISITS PROVIDED BY NAMDS MEMBERS IN 2014 WERE PROVIDED IN THE 'UNSOCIABLE' HOURS BETWEEN 11PM AND 7.00AM, A TIME WHEN ACCESS TO OTHER MEDICAL CARE IS LIMITED TO EMERGENCY SERVICES AND ED DEPARTMENTS.

### HISTORY

NAMDS finalised a set of standards and introduced accreditation of member services according to these standards in 1993. NAMDS subsequently instigated and succeeded in having these standards incorporated into the RACGP's 'Entry Standards for General Practice'. The premise for this initiative was, and remains, that accreditation of General Practice is deficient without co-accreditation of those after-hours arrangements delivering a clinical continuum to patients for up to 118 hours, or 70%, of the week.

In addition to its proactive and forthright role in determining appropriate standards for MDS accreditation, NAMDS has been integral in achieving many other important developments in Australian after hours GP service delivery. These include:

- An increased rebate for Schedule A after hours MBS Items of Service in 1998
- The introduction of the National AHPMC trials
- The introduction of the Approved Medical Deputising Service Program
- Development of a post-graduate training program in after-hours primary medical care and medical deputising in conjunction with the RACGP
- The National Medical Deputising Workshop
- Negotiation of increases in the rebate for after hours MBS Items of Service in 2000 and additional increases for non-VR doctors in 2001
- Recognition as the peak negotiating body for the Medical Deputising sector amongst Government at State and Federal levels and other peak medical representative organisations.

Achievements in raising standards of after hours services provided by General Practice and recognition of the importance of a quality-based continuum in clinical care has resulted principally from NAMDS' efforts.



## The Role of Deputising in the After Hours System

MEDICAL DEPUTISING PLAYS A CRITICAL AND GROWING ROLE WITHIN THE AFTER HOURS SYSTEM, DELIVERING HIGH QUALITY CARE WHEN IT IS NEEDED MOST.

NAMDS BELIEVE THAT HOME VISITING MEDICAL DEPUTISING SERVICES PROVIDE THE SINGLE MOST POTENT, AND YET MOST OVERLOOKED, RESPONSE TO THIS MODERN HEALTH CARE CHALLENGE.

State and Federal Governments alike know that the most significant cost pressures on our health care system come from people using high cost hospital care, who could have received more timely and appropriate care in the community. Whether it's people using Emergency Departments for GP like presentations, nursing home residents being transported by ambulance for matters that could have been handled in the facility, or people with chronic illnesses experiencing potentially avoidable hospitalisations, the impact is felt not just in terms of cost but also in worse health outcomes for the individuals involved. The challenge is how to provide better access to primary care so that this inappropriate use of hospital resources is minimised.

NAMDS believe that a strong system of GP Primary Care supported by out of hours home visiting Medical Deputising Services provide the single most potent, and yet most overlooked, response to this modern health care challenge.

Historically, there have been good reasons for overlooking home visiting as a solution. GPs have been withdrawing from home visiting and after hours practice and specialist home visiting services were historically small, fragmented and low-tech and had difficulty attracting sufficient doctors. However, the emergence of large, technology enabled services with significant local scale in each major city changes the equation. These services blend the personal touch of a doctor making a house call to a sick patient, with efficiency and consistent quality enabled by modern communications technologies and rigorous clinical governance frameworks.

Medical Deputising already plays a critical role in the after hours medical care system in Australia. NAMDS estimate that Medical Deputising provides approximately 1.7 million episodes of care nationally every year. This compares to 3.6 million low acuity episodes of care (triage category 4 & 5 patients) being carried out in public hospital emergency departments, approximately 55% of which occur during the after hours period. Extended hours and after hours clinics provide approximately 7 million episodes of care.

Medical Deputising plays a significant role in the broader primary care sector by addressing two critical challenges:

**i. Declining GP Home Visits** – There has been a long-term structural decline in home visits by regular GPs (see Figure 4) and more than 80% of GPs report doing no home visits (BEACH survey data). This poses special challenges to aged care facilities and HACC recipients in particular, as well as to individuals with poor mobility or limited access to transport. While Medical Deputising has been growing in recent years, it is far from replacing the declining level of GP Home Visiting.

**ii. Timely access to episodic care in the broader primary health care system.** ABS Survey data show that approximately three quarters of patients have difficulty accessing same day care from their regular GP. Deputising provides another alternative for patients to get timely access to urgently required episodic care. Increasing rates of workforce participation by mothers means that after hours options are also increasingly important for accessing episodic care for children with parents often only becoming aware of a child's urgent medical need in the late afternoon after collecting them from formal or informal childcare.

Medical Deputising Services are distinctive in the after hours sector due to:

**i. Complete after hours coverage** – Unlike most extended hours clinics, NAMDS members provide care right through the unsociable hours (right through the night to 8:00 am) and right across the metropolitan area.

**ii. Accessibility for vulnerable patients** – NAMDS members see a very high proportion of patients in vulnerable situations who otherwise may not be able to access after hours care, or would otherwise inappropriately access emergency care. This includes nursing home residents who can make up between 10 - 40% of the nightly caseload. Infants and young children make up the other large proportion of the caseload, with patients under 4 years of age comprising 20 - 40% of nightly caseload. Care responsibilities for siblings often make it difficult for parents to access other forms of care. Other key patient groups include people with poor mobility or poor access to transport and people with carer responsibilities.

**iii. Potency in relieving pressure on ambulance and emergency** – Providing the community with access to responsive after hours healthcare has been a frustrating challenge for successive State and Federal Governments. GP Super Clinics, walk in nurse clinics and telephone help lines have all been tried but found wanting due to service limitations, community resistance and the need for ongoing operating cost subsidies.

In truth, the best solution has been there all along: doctor home visits provided by accredited Medical Deputising Services (MDS). MDS provide an appropriate alternative for lower acuity presentations that may otherwise be addressed by an ambulance transport (average cost \$600-\$800) and a presentation at an Emergency Department (average cost to the healthcare system of \$250-\$500).

A survey of patients conducted by NAMDS enquiring as to what the patient would have done in the absence of the medical deputising service indicate that 40% of patients (excluding those in Nursing Homes) would have either called an ambulance or presented at an ED had they not been aware of the service (see Figure 3).

National data supports these patient self reported beliefs, with a strong correlation between penetration of Medical Deputising and lower levels of low acuity presentations at ED. In 2013, Queensland recorded approximately 65 after hours home visits per 1000 population and about 120 category 4 and 5 ED presentations per 1000 population. By contrast, NSW had only 23 after hours home visits per 1000 population and around 170 category 4 and 5 ED presentations. Victoria experienced 50 after hours home visits per 1000 and 147 low acuity ED presentations per 1000.

In Victoria over a ten year period, declining access to home visiting was associated with an increase in low acuity ED presentations. In addition, ABS survey data shows that 1 in 4 people presenting to Emergency Departments state that their main reason for going to Emergency was the time of day or day of week, and this proportion is significantly higher in states such as NSW (57%) where the penetration of Medical Deputising is markedly lower.

**iv. True continuity of care** – medical deputising consistently ensures direct delivery of patient reports to GPs. This is not always the case with Emergency Departments – where communication often depends on the patient conveying a letter to the regular GP – nor is it the case with extended hours medical clinics that are often in competition with daytime GP practices. In essence while after hours clinics provide a parallel or competitive service to the Family GP, medical deputising completes the 24/7 day loop for and on behalf of the Family GP.

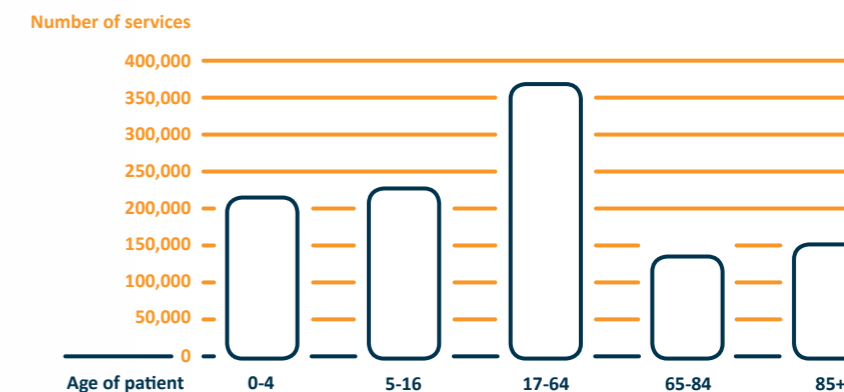


Figure 1. Number of patients seen by NAMDS members in residential settings or aged care facilities by age group, Australia, 2014 financial year.



## Challenges & Opportunities for Medical Deputising



MEDICAL DEPUTISING HAS GROWN AS A SECTOR OVER THE LAST SEVERAL YEARS ON THE BASIS OF SEVERAL FACTORS. HOWEVER, THIS GROWTH HAS GENERATED A NUMBER OF CHALLENGES OF ITS OWN.

The current situation and emerging challenges are discussed below:

### i. Engagement of the GP community:

GPs historically were highly engaged with medical deputising as it provided a genuine alternative to day-time GPs having to work 24/7. This relationship was formalised through the Quality Accreditation standards and through the PIP funding that flowed with that. When Medicare Locals became responsible for after hours funding and the RACGP modified the interpretation of the accreditation standard regarding after hours care, the previously high level of engagement that NAMDS members had with the GP community was undermined. While most GPs have remained well engaged, this is not true for all (we have reports of GPs saying 'this is not my concern anymore; the Medicare Local is now responsible'). Recently the Australian Government has restored the AH PIP. NAMDS welcome this as a first step towards improved GP engagement and look forward to the RACGP returning to its former interpretation of the standard.

### ii. Awareness among the patient community:

Awareness of medical deputising had begun to increase over the last few years as MDS have increased expenditure on community awareness programs, supported in some cases by Medicare Locals. However, there are still large proportions of the community, especially in the largest cities, who are unaware of the availability of medical deputising. Our market research confirms that the vast majority of patients are still unaware they have a viable alternative to attendance at an ED in the after hours period.

### iii. Sufficient supply of doctors interested in a long term career in deputising:

The Approved Medical Deputising Service Program (AMDSP) has permitted access to a workforce that has enabled the Medical Deputising Services to meet demand. However, this group have largely regarded deputising as a temporary phase in their career as they work towards Fellowship of the College and their own provider number.

Quality medical care depends, in part, on the long term engagement of clinical leaders in the organisation as practicing doctors. As we look ahead to increased demand, and also to an increased supply of medical graduates, we believe there is an opportunity to reach a broader pool of doctors and interest some of them in a longer term career as an after-hours doctor.

NAMDS have already begun to explore the potential for GP Training programs to include a rotation in deputising as an opportunity for trainees to enhance their skills in episodic care outside the clinic environment and to discover more about what a career in deputising could involve.

### iv. Access to predictable funding to support innovation and expansion:

Medicare Benefits payments reward doctors for service delivery, with service fees being paid from these amounts to MDS's to cover the recurring costs of reception, payments processing, electronic communications, clinical support, training, patient reporting and so on.

Historically, the MDS used the additional funding stream of GP subscription payments to help support investments in improved IT and communication systems, investments in electronic communications systems to allow faster processing of patient reports to GPs, and subsidies to support provision through the unsociable hours and expansion of coverage areas to new territories on the urban fringe and in regional areas.

The shift of after hours funding responsibility to Medicare Locals disrupted funding predictability and reduced overall funding levels. After hours funding (other than Medicare Benefits payments) received by NAMDS members declined by around 40% over the last two years, while reporting and documentation requirements have dramatically increased. Funding changes have been sudden and seemingly capricious.

For example, two MLs in Melbourne reduced after hours funding to NAMDS members by 75% with less than 4 weeks notice and limited consultation.

Without the additional funding streams above and beyond the Medicare Benefits Schedule payments, there is limited capacity to fund innovation and extension.

Key innovation and extension priorities that will require investment over coming years include:

- Systems integration to electronic personal health records
- Extension to mid-sized regional cities
- Extension to urban fringe areas with lower populations densities
- Extension of new, more appropriate services to vulnerable groups such as Aboriginals and Torres Strait Islanders; people in institutions; and homeless people
- Extension to community based palliative care programs
- Extension to hospital-in-the-home initiatives.

### v. Better Integration with Healthdirect:

Healthdirect provides an alternative for individuals and carers to get advice regarding the appropriate level of care to access given their circumstances. The website provides good details on clinic hours and contact details so that patients can access their primary provider easily. During regular practice hours, the Healthdirect advice line also provides a good service in linking patients back to their "Medical Home" when this is the most appropriate course of action.

However, during the after hours period, this connection breaks down. Patients looking on the website are not informed about deputising services. Patients who call the advice line and need to see a doctor that night are typically referred to extended hours clinics or hospitals or given a choice of deputising services to call rather than referred to their GP's Deputising Service. The fact that the National Health Directory does not record the Deputising Service for each GP clinic is an unnecessary flaw that undermines continuity of care and the Medical Home.

**vi. A new frontier for integrated care**—A mobile doctor workforce provides a new dimension for planning and delivering integrated care models that help minimise preventable admissions to hospital of people with chronic illnesses. We know that people with chronic illnesses face many challenges in accessing appropriate primary care – from mobility challenges to lack of transport to full-time carer responsibilities. Some patients lack the motivation or the personal organisation to make and keep out of home appointments. Integrating home visiting doctors with GP care plans, community nursing, personal care, and telephone support offers a potent way to ensure earlier intervention that prevents more severe exacerbations of underlying conditions and minimises the risk of potentially avoidable hospitalisations.

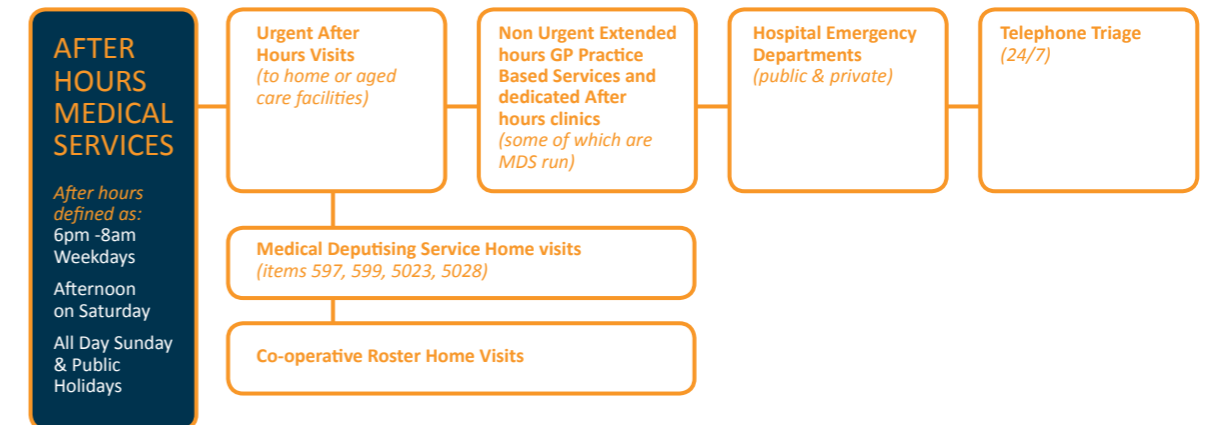


## After Hours Medical Care Services in Australia

### NAMDS AFTER HOURS PRIMARY MEDICAL CARE SUMMARY

#### AFTER HOURS MEDICAL SERVICES MARKET DEFINITION: URGENT & NON URGENT

The After Hours Medical Services market comprises a number of different service delivery types:



	Urgent After Hours Visits	Non Urgent Extended hours GP Practice Based Services and dedicated After hours clinics	Hospital Emergency Departments	Telephone Triage	Medical Deputising Service Home visits
<b>Attendances per annum (2013)</b>	1.51m	0.21m	7.23m	2.46m	Small
<b>Share of After Hours Services</b>	13.23%	1.84%	63.36%	21.56%	Small
<b>Definition</b>	<ul style="list-style-type: none"> <li>After hours Medical Deputising Service subscribed to by individual GP Practices</li> <li>May take the legal form of a company or a not-for-profit enterprise</li> <li>MDS Role: Increasing</li> </ul>	<ul style="list-style-type: none"> <li>After hours visits are carried out by a GP from within the practice on a roster basis</li> <li>Multiple GP practices may cooperate to spread the load and reduce the number of on-call nights per GP</li> <li>Role: Decreasing rapidly, except in rural and sub-regional areas</li> </ul>	<ul style="list-style-type: none"> <li>Extended hours clinics and/or specialist after hours clinics</li> <li>After hours clinics generally close before 11pm weeknights and 8pm on weekends</li> <li>Role: Increasing in metropolitan Australia</li> </ul>	<ul style="list-style-type: none"> <li>Number of after hours non-admitted emergency visits in "Non-urgent" and "Semi-Urgent" triage categories, presenting at public hospitals by state in fiscal year 2012-13 (assumes that 70% of presentations were in the after hours period, including weekends)<sup>1</sup></li> <li>Data excludes private hospital ED attendances</li> <li>Role: Public, increasing</li> <li>Role: Private, static</li> </ul>	<ul style="list-style-type: none"> <li>National/ State run GP and nurse triage systems are in operation.</li> <li>Provides advice to patients and directs them to the most appropriate form of care.</li> <li>Majority of advice continues to be face to face doctor attendance, largely at public hospitals, GP clinics, extended after hours clinics or MDS.</li> </ul>

<sup>1</sup> Source: Australian Institute of Health and Welfare – Hospital Statistics 2013

Figure 2.

#### IF YOU HAD NOT KNOWN YOU COULD CALL A MEDICAL DEPUTISING SERVICE, WHAT DO YOU THINK YOU WOULD HAVE DONE TO ACCESS MEDICAL CARE?

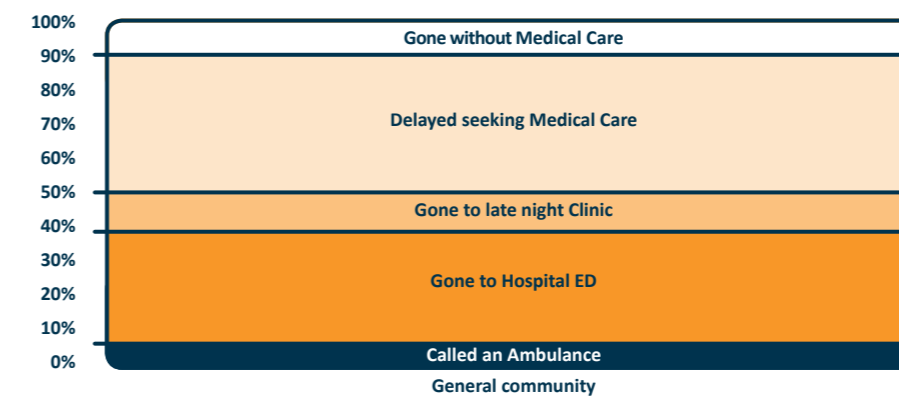


Figure 3.

#### HOME VISITS BY DOCTORS (MEDICARE SERVICES PER CAPITA)

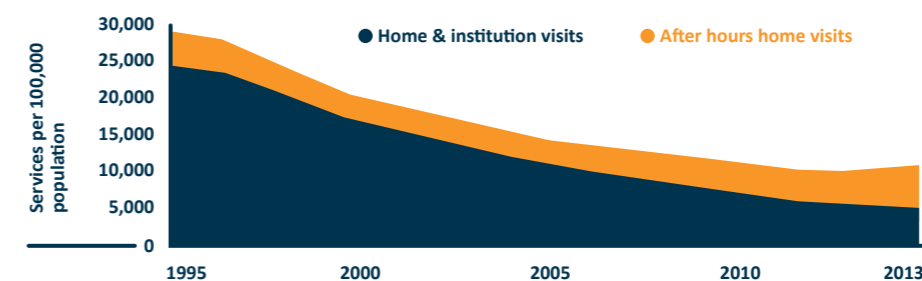
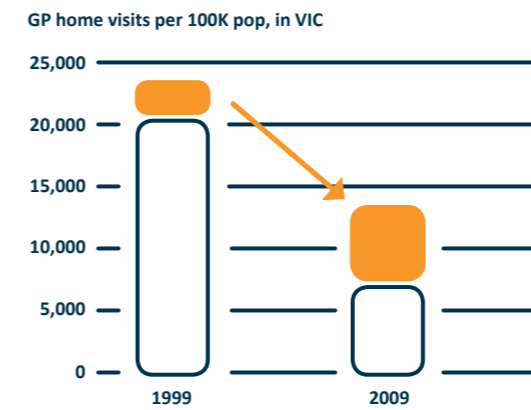


Figure 4.

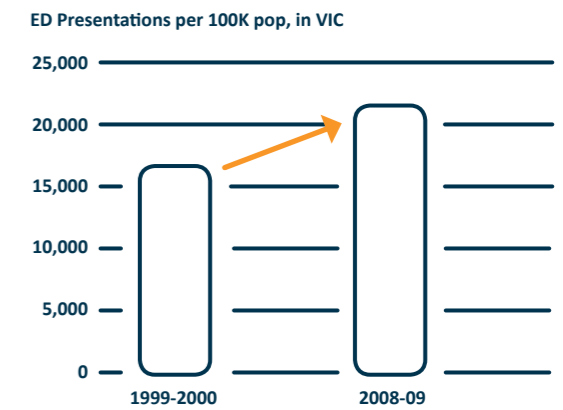
THERE IS STILL HUGE UNMET DEMAND FOR HOME VISITS



**GP HOME VISITS PER CAPITA DECLINED BY OVER 40% IN 10 YEARS**



**OVER THE SAME PERIOD, ED PRESENTATIONS PER CAPITA HAVE INCREASED BY 30%**



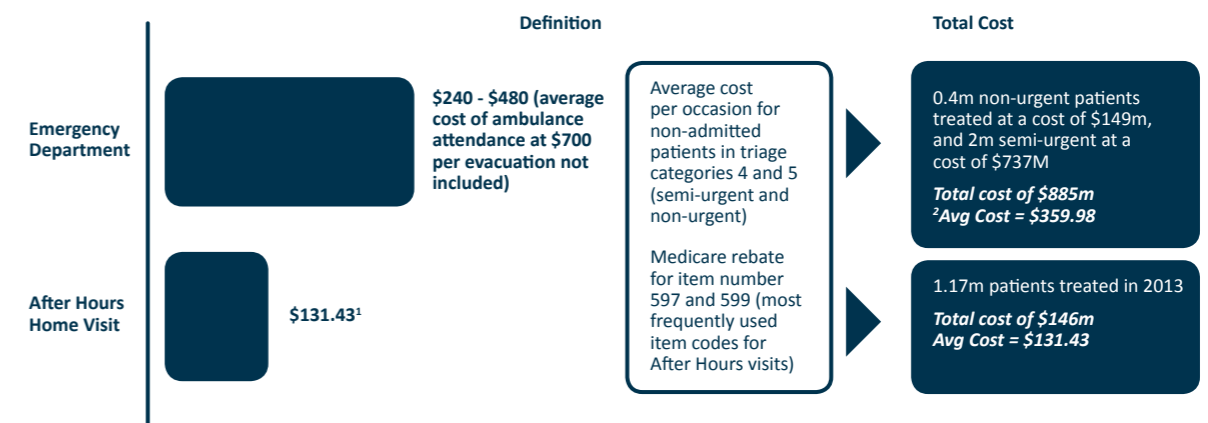
**VICTORIAN EXPERIENCE HIGHLIGHTS RELATIONSHIP BETWEEN ACCESS TO HOME VISITS AND ED PRESENTATIONS**

Figure 5.

**HOSPITALS - ECONOMICS OF AFTER HOURS PRIMARY MEDICAL CARE PATIENTS**

The cost to the governments is significantly higher when patients are treated in the ED versus an after hours visit from a GP.

**Average cost per occasion of service**



The average cost of treating a non-urgent case in an Emergency Department is higher than the cost of an after hours attendance(excluding and ambulance costs) - and contributes significantly to waiting list build-ups; as such it does not represent a preferable alternative for Australia.

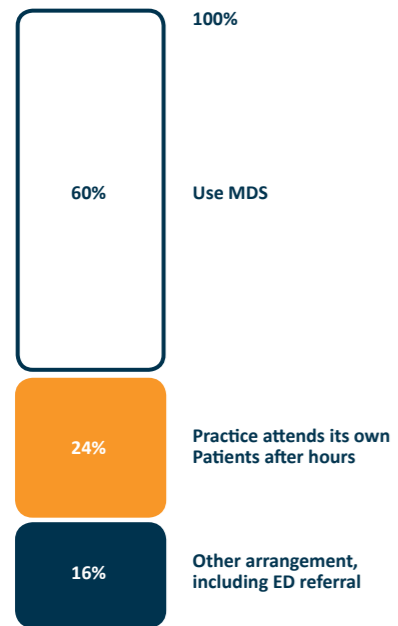
<sup>1</sup> Based on the average urgent after hours attendance cost from the Medicare Benefits Schedule 2014.  
<sup>2</sup> Calculation based on number of after hours, non-admitted emergency department attendances by the average cost of an emergency department visit (\$360).

Figure 6.

## GP Propensity to Subscribe to MDS

### 60% OF ALL AUSTRALIAN GPs SUBSCRIBED TO AN MDS SERVICE

In 2009, around 60% of all Australian GPs subscribed to an MDS service. The propensity to subscribe at that time was driven by a number of factors. This changed with the advent of Medicare Locals taking control of after hours in 2012 and subsequent changes to the RACGP standards allowing GPs to opt out of providing and/or organising 24/7 patient care.



Representative Sample of Australian GPs N=100

Notes: This includes Co-operative GP groups

Source: BEACH (annual survey of 1000 individual GPs)

Figure 7.

There are a number of key factors that influenced pre 2012 GP subscriptions to MDS services; ie prior to the advent of Medicare Locals:

**Regulation** – to become accredited, Practices needed to adhere to RACGP Standards. These Standards required practices to provide access to after hours visits. In return, the Government provided a series of financial incentives called PIP incentives.

**GP Preferences towards working sociable hours** – pre 2012, Accredited GP Practices could choose to provide after hours coverage themselves in return for higher PIP incentives, or opt to outsource to an MDS service for a lower set of incentives. Note, unaccredited GPs may also subscribe to an MDS service, generally out of a sense of duty to their patients.

**Availability of a local MDS provider to meet GP requirements for after hours care** – MDS providers do not provide full national coverage, so GPs in regional/rural/remote areas often had no choice but to provide after hours services themselves to meet the RACGP standards.

DEMAND FOR MDS PROVISION BY GPs HAS IN THE PAST BEEN DRIVEN BY THE VOLUNTARY PRACTICE ACCREDITATION PROCESS WHICH REQUIRES GPs TO ENSURE ACCESS TO AFTER HOURS VISITS (AND 24/7 PATIENT CARE COORDINATION).

General Practice Accreditation (RACGP)

- Prior to 2012, the means for **upholding general practice standards in Australia was via an RACGP accreditation** process, that ensured that best Practice Standards of care are in place 24/7
- Whilst **accreditation was voluntary, it gave the practice access to a number of “Practice Incentive Payments”** - essentially a set of grants from the Commonwealth Government
- Prior to 2012, one of the accreditation requirements was that Practices **provide access to after hours home visits** to their patients
- If the Practices chose not to provide after hours home visits themselves, they were required to have a **formal agreement** in place with another organization that provides the access on their behalf – generally an **MDS organisation or co-operative (in regional Australia)**
- However in July 2013, the RACGP amended its after hours standard in relation to Criterion 1.1.4 where it now states that; “Practices are required to demonstrate that they are aware of arrangements in place for their patients to access after-hours care, and Practices are required to have processes in place to alert patients to these arrangements”
- This new RACGP interpretation allows GP Practices, Australia wide to refer patients to ED, Health Direct or next day care rather than provide and/or organise the provision of face-to-face 24/7 care from within their Practice. In the view of NAMDS, this is a substantial adverse change to the Australian primary medical care system and one not intended by Government.

### RACGP Standards for After Hours Visits

There are two accreditation agencies (AGPAL and GPA). In order to be accredited, General Practices must meet the standards developed by the Royal Australian College of General Practitioners (RACGP)

In the 4th Edition of the Standards, the sections that influence provision of after hours visits state that:

- **CRITERION 1.1.3 Home and other visits**
  - Regular patients of our practice are able to obtain visits (where such visits are safe and reasonable) in their home, residential aged care facility, residential care facility or hospital, both within and outside normal opening hours
- **CRITERION 1.1.4 Care outside normal opening hours**
  - Our practice ensures safe and reasonable arrangements for medical care for patients outside our normal opening hours
  - Practices need a formal agreement with the alternate provider





## Definition of a Medical Deputising Service

AN ORGANISATION WILL BE DEEMED TO MEET THIS DEFINITION OF A MEDICAL DEPUTISING SERVICE IF IT IS ACCREDITED TO THE CURRENT ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS STANDARDS FOR GENERAL PRACTICE, INCLUDING SUPPLEMENTARY MATERIALS FOR AFTER HOURS CARE SERVICES (AS DETERMINED BY THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS FROM TIME TO TIME) AND IS ACCREDITED TO CONFIRM IT MEETS ALL THE FOLLOWING ADDITIONAL CRITERIA.

### DEFINITION

- A Practice Principal is a registered medical practitioner (vocationally recognised or not, full-time or part-time), who undertakes the continuing care of patients in a medical practice. The Practice Principal has a responsibility to arrange comprehensive care of patients 24 hours a day and engages the MDS
- A Medical Deputising Service is an organization which directly arranges for medical practitioners to provide after hours medical services to patients of Practice Principals during the absence of, and at the request of, the Practice Principals
- A Medical Deputising Service is a means whereby a Practice Principal may externally contract the after hours components of both continuous access to care and continuity of care to Practice patients
- A Medical Deputising Service utilises facilities and processes which ensure continuous access to care and continuity of patient care
- A Medical Deputising Service comprises a physical facility which incorporates a control communications / operations capacity, administrative services and, where applicable, a clinic
- A Medical Deputising Service must provide home visits and may also provide clinic and telephone triage / medical advice services. Medical Deputising Services must ensure that they are always in a position to provide home visits as required for significant medical reasons or as requested by Practice Principals, throughout the entire after hours period
- A Medical Deputising Service responds to patient or principal-initiated calls only and must not provide planned or routine patient services unless agreed with the patient's principal practitioner
- A Medical Deputising Service must not schedule appointments beyond the after hours period in which the patient request was received
- A Medical Deputising Service is required to operate and provide uninterrupted access to care, including home visits, for the whole of the after hours period. The defined after hours periods that must be covered by the Medical Deputising Service are: any time outside 8am - 6pm on weekdays and all day weekends and public holidays. A Medical Deputising Service must demonstrate that consultations and visits are provided during the unsociable hours from 11pm till 7am
- In providing complementary care on behalf of local, daytime general practice, a Medical Deputising Service must be independent of any individual or group of general practice(s). Medical Deputising Service premises must not be co-located with a general practice
- As Medical Deputising Services do not offer comprehensive GP care, direct advertising to encourage patients to use Medical Deputising Services for 'routine' or convenience purposes, thereby compromising their access to the full range of GP services, is prohibited
- A Medical Deputising Service must have a control / communications / operations capacity which must be operational within its premises during the majority of the defined after hours period
- A Medical Deputising Service which contracts out part of its control / communications / operations function may only do so to an MDS accredited control / communications / operations service
- The control / communications / operations room must, during the after hours period, be staffed by personnel appropriately trained in telephone triage, to guarantee maintenance of accreditation standards and ensure the appropriate management of urgent cases
- A Medical Deputising Service must have telephones attended 24 hours per day by trained staff so the Principals can access the service to communicate special patient information and facilitate continuity of care at all times.

*Note: As it is not presently recognised by Medicare Australia that the period Saturday 8am to Noon Saturday is part of the recognised After Hours period with respect to the availability of Urgent After Hours Items, then this period is not included in the defined After Hours period that must be covered by the Medical Deputising Service. NAMDS hopes to finalise negotiations with Government to rectify this anomaly.*

## Joining NAMDS

### MEDICAL DEPUTISING SERVICES WISHING TO BECOME MEMBERS OF NAMDS ARE REQUIRED TO MEET THESE CRITERIA:

- Accreditation to RACGP Standards
- Meet the NAMDS Definition of a Medical Deputising Service
- Submit a written application for membership as a Medical Deputising Service, with the applicable fee and required documentation
- Affiliate membership is available for organisations that do not meet the NAMDS Definition of a Medical Deputising Service. Affiliate members do not have voting rights.

### PROCESS

- MDS applicant provides the NAMDS Secretary with a written application accompanied by required attachments and entry fee
- The Board will consider an application within 14 days of its receipt by the Secretary
- MDS applicant will receive formal notification from the Board within 14 days of the membership decision
- Approval by the Board and membership ratification is subject to receipt from the MDS applicant of the annual subscription fee.

Fees (including GST) All Fees subject to annual CPI Increase.

Entry fee payable upon application	\$2500.00 small MDS \$5000.00 large MDS
Affiliate membership application	\$250.00

*First annual membership fee is payable upon application and thereafter annually on the 30th day of June each year.*

Annual fee for an MDS classified as a large service - > 25,000 pt attendance per year	\$2100.00
Annual fee for an MDS classified as a small to medium service – < 25,000 pt attendance per year	\$1050.00
Annual fee for Affiliate membership	\$300.00

*A member admitted after the 1st day of August in each year shall pay the proportion of the annual subscription remaining for the period calculated to the nearest month.*

*Dues and levies will apply and the annual membership fee will be amended from time to time in accordance with the processes provided by the Articles of Association.*



## CONTACT

Please address all enquiries and correspondence to:

Nicolas Richardson

**Secretary / Treasurer NAMDS**

Suite 2/2 Salisbury Street, Richmond

Melbourne, VIC 3121

E [nicrichardson@namds.com](mailto:nicrichardson@namds.com)

[www.namds.com](http://www.namds.com)