RACGP
Royal Australian College *of* General Practitioners

Healthy Profession.
Healthy Australia.

RACGP submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Issues paper: Emergency Planning and Response

1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability for the opportunity to provide a submission in response to its issues paper on emergency planning and response.

The RACGP is Australia's largest professional general practice organisation, representing over 41,000 members working in or toward a career in general practice.

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for training
- maintaining the standards for quality general practice
- supporting specialist general practitioners (GPs) in their pursuit of excellence in patient and community service.

2. Ensuring greater support for people with disability during emergencies

It is critical there is recognition by everyone involved in emergency support that people with disability, among other vulnerable populations, take priority in terms of accessing assistance.

To increase the safety and wellbeing of people with disability during emergencies, RACGP members have recommended the following steps be taken:

- ensuring any emergency and disaster planning involves explicit strategies and steps for people with disability, as an especially vulnerable group, including in the post-emergency and recovery phases
- establishing subcommittees of emergency planning and response teams specifically focussed on addressing the needs of people with disability
- ensuring access to skilled healthcare workers as part of emergency planning to fill gaps in emergency health provision
- developing tailored information to ensure vulnerable groups receive specific health information and advice relevant to their personal situations, as well as to alleviate any anxiety that may be experienced during emergencies.

3. Role of GPs in supporting people with disability during emergencies

GPs are essential to emergency planning and must be involved in co-design at a local, regional and national level.

To ensure GPs are equipped to appropriately support people with disability during emergencies, our members have called for the following:

- involving GPs at the outset of any emergency response and engaging in meaningful consultation and dialogue with the RACGP
- providing consistent messaging during emergencies. GPs report messaging during the COVID-19 pandemic has been varied and inconsistent, and many practices were left to design their own management protocols
- providing emergency consulting spaces, clinical equipment and supplies where needed

- minimising red tape and barriers to engaging GPs during the emergency Temporary provider numbers and emergency measures to allow access to Medicare services in hospital settings could prevent the need to employ and on-board GPs into local hospital human resources systems
- creating a register of patients with disability that can be accessed by GPs in emergencies
- enabling more flexible diagnostic coding and electronic medical record search strategies so GPs can easily locate 'at risk' registries for vulnerable groups. For example, most general practices cannot identify through their datasets who is in a who is in a care facility, supported accommodation or in receipt of a home care package. This information which is key to be able to target these patients promptly. This may be a complex task due to the various classifications of disability and levels of need. It is therefore necessary to stratify risk categories on an agreed matrix.

3.1. Telehealth services

GPs have adapted quickly to providing care during the ongoing COVID-19 pandemic, with significant and rapid uptake of Medicare Benefits Schedule (MBS) telehealth items. A recent RACGP survey found 99% of practices are delivering telehealth consultations.

Telehealth offers numerous benefits and has demonstrated care can be effective when delivered remotely, challenging traditional concept of face-to-face consultations being the only effective medium to support patient care. It is important to note that telehealth is not a substitute for face-to-face care and should only be used where safe and clinically appropriate.

Our members report extending access to telehealth services beyond COVID-19 would allow time to gradually alleviate patient concerns about the safety of receiving face-to-face care. In the absence of a COVID-19 vaccine, the continuation of telehealth could also form part of an ongoing strategy to reduce the risk of infection in the community. This ensures vulnerable populations, including people with disability, continue to have access to essential services.

Enabling rapid access to telehealth during an emergency may assist people with disability who cannot access healthcare in person. This may require consideration of expanding clinical situations where telehealth is considered an appropriate means of service delivery.

The RACGP welcomed the recent government announcement that telehealth service provision must be linked to a patient's regular GP or practice. This will limit the increase in on-demand telehealth services and facilitate delivery of higher quality primary healthcare by GPs/practices that have an existing relationship with a patient and knowledge of their medical history. It may also lead to a reduction in overall healthcare costs by reducing service and care duplication and increasing the capacity for GPs/practices to provide more complex and comprehensive care.

The RACGP acknowledges there are some circumstances in which it may be appropriate for a GP to deliver services to an unknown patient via telehealth. There are GPs across the country who focus on providing specialised care to particular patient cohorts, including people with different types of disability. It may therefore be appropriate to loosen restrictions on accessing telehealth for people with disability during declared emergencies. The RACGP would be willing to work with government to consider circumstances where further exemptions to those already allowed would be appropriate.

4. Preventing and responding to violence, abuse, neglect and exploitation

Our members have noted outreach services, such as welfare checks by GPs, are key to preventing and responding to cases of violence, abuse, neglect and exploitation. These checks may occur face-to-face or virtually depending on the situation and the individual.

It is imperative the disability workforce is well trained and well paid, and is governed by high standards of safety and quality. Members have raised concerns some providers put profits before the wellbeing of clients. Effective regulation of service providers must be the responsibility of the NDIS Quality and Safeguards Commission. Another option to prevent mismanagement could be the establishment of accreditation committees with the power to withdraw funding from service providers, as currently occurs with health services.

GPs are often frustrated by delays, poor responsiveness and a lack of feedback when trying to alert relevant authorities about possible cases of abuse. A combination of co-designed pathways and personal engagement between GPs and the responsible officers would greatly improve the flow of information. Trusted relationships would allow for discussion of cases that may not reach a threshold for formal reporting, for the purposes of early intervention.

5. Communication measures to improve safety

There is potential for fixed phone lines to be impacted by power disruptions and mobile phone reception to be affected in emergency situations (eg due to damage to mobile phone towers during storms and fires). Mobile phone networks can become rapidly congested during a disaster, particularly in major urban centres.

An emergency hotline service could be one option to help people with disability keep safe and informed during an emergency. The effectiveness of a hotline would largely depend on having a sufficient number of suitably trained support workers to answer calls. This service also assumes people with disability are able to make calls when needed, when in fact they may be isolated and unable to communicate.

The hotline is not the only solution, A mix of technologies is needed to ensure people with disability receive important information during emergencies, with consistent messaging across different mediums. Mobile phones can be very useful as a tool to receive emergency broadcasts. The utility of lower technology radio broadcast systems should not be underestimated in rural and regional areas.

An outreach service may be a better option for more effectively targeting people with disability. This could be achieved by providing funding for GPs to establish a database of vulnerable people who may need extra assistance in emergencies, with information on how best to contact them. This could be complemented with funding for software vendors to develop the ability to capture data to assist in identifying these people from GP records.

Our members have suggested emergency communication equipment be provided to general practices on an ‘as needs’ basis to help coordinate care. Provision of this equipment could be overseen by Primary Health Networks (PHNs) or an equivalent authority.

6. Conclusion

The RACGP thanks the Royal Commission for the opportunity to provide this submission. If you would like to discuss the RACGP’s submission further, please contact Joanne Hereward, Program Manager – Practice Technology and Management at joanne.hereward@racgp.org.au or on 03 8699 0338.