MidCentral District Health Board

and

Horowhenua, Manawatu, Otaki and Tararua

Primary Health Organisations

District Wide After Hours Plan

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1. OVERVIEW

All communities need to have access to effective, efficient and sustainable health services on a 24 hour, 7 day a week basis. After hours first contact primary health care services are a very important part of this spectrum. Over recent years, provision of after hours primary health care has become more problematic because of a variety of factors. They include the changing nature of the health professional workforce, changes in the way health services are organised and changes in communities' needs for and expectations of services. None of these factors are unique to the MidCentral district. After hours care has been raised as an issue at the national level and there is an obligation on all DHBs to produce an after hours plan.

This Plan seeks to provide a broad framework for after hours primary health care services for the MidCentral district. The objective is that the framework provides a basis for after hours services that are sustainable within our existing (and likely future) health workforce, affordable from a funding perspective and effective in meeting the needs of our communities. The framework also needs to be consistent with the DHB's local Primary Health Care Strategy, which emphasises the development of primary health care teams, investment in primary health care infrastructure and responsiveness of services to community needs.

Within the MidCentral district, communities are too geographically distributed to be served by a single after hours service. MidCentral's PHOs are geographically based serving distinct communities that correspond to Territorial Local Authority boundaries. Each PHO has a different combination of resources and community needs. Consequently, as well as providing a district wide framework, this Plan also provides specific arrangements for each PHO area. These arrangements need to be flexible over time to accommodate changing circumstances at the local level.

From a contractual perspective, responsibility for providing after hours primary health care services rests with Primary Health Organisations. The contracts PHOs hold with the District Health Board state the following:

> *H.3.1 You will provide access to First Level Services on a 24-hour a day, 7 day a week basis for 52 weeks a year for all Service Users.*
>
> *H.3.2 First Level Services must be available for 95% of your Enrolled Population during:*
>
> *(a) the normal Business Day within 30 minutes travelling time; and*
>
> *(b) after hours within 60 minutes travel time.*

PHOs in turn include the obligation in the contracts they hold with GPs. However given the issues involved in providing after hours care, a collaborative DHB-wide approach is needed.

However, afterhours care is not just about general practices services. It also includes nursing, pharmacy, radiology, laboratory, emergency department, ambulance and telephone triage services

All four PHOs in the MidCentral district have worked with the DHB to develop the overarching framework. Individual PHOs have then worked to develop local plans.

1.1 Definition of After Hours Care and Scope of the Plan

In 2005, the National After Hours Working Party was established in response to emerging issues with the provision of after hours primary health care. This multi-party Working Party released its report in October 2005. This report defined After Hours Care as follows:

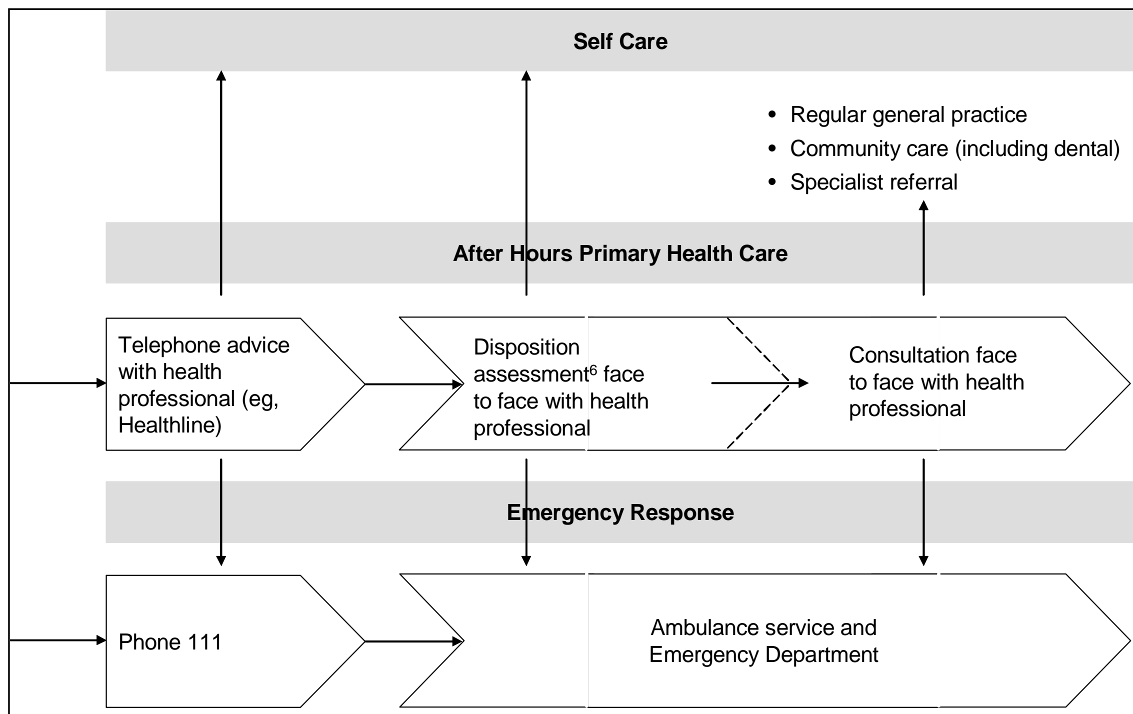
> *After hours primary health care is designed to meet the needs of patients that cannot be safely deferred until regular or local general practice services are next available.*

Within this context, "patient" is defined as including both enrolled and casual patients and "regular general practice services" are those services provided when the practice where the patient is enrolled is routinely open.

The Working Party's definition has been used for the purposes of this Plan.

One important consideration is that the definition does not include people who wish to access primary health care outside of normal working hours for personal convenience - for example to fit in with the patient's work obligations. Some practices have the capacity to accommodate this type of demand, but there is no requirement on practices to do so. Neither is it the purpose of this Plan to establish services to meet patient convenience. Rather the focus is on people who need primary health care because it is not safe for them to wait for routine services.

Figure 1: After Hours Primary Health Care



After hours primary health care is strongly related to a number of other services. It fits within the broader context of emergency health care, which interfaces with services such as Emergency

Department, Ambulance Services, mental health services and 24 hour district nursing services. A separate project is underway working on district wide emergency services. The DHB is also in the process of developing a Rural Health Strategy. This also relates to after hours services given that service provision is most difficult in the smaller rural communities.

After hours services are not just about General Practitioners. It also includes nursing, pharmacy, radiology, laboratory and telephone triage services.

2. Current Access to After Hours Care

2.2 Service Availability

The after hours arrangements currently in place within MidCentral's district vary from community to community. Traditionally after hours care was provided by GPs according to rosters worked out on a collegial basis. These arrangements still prevail in most communities. There are other forms of after hour service present in the district – such as Accident and Medical centres, nurse triage and telephone triage services. The following table provides a brief outline of the services in place in each PHO area based on a stocktake of services undertaken in November 2006.

	5pm to 11pm	11pm to 8am
Tararua	Rostered GPs Some scheduled clinics Local nurse triage (telephone & some drop in)	Local nurse triage (telephone & some drop in) ED cover from PNH
Manawatu	Feilding Rostered GPs	ED cover from PNH
	Palmerston North A&M City Doctors, until 10pm A&M Radius Medical, until 9pm Radius Medical telephone 9-11pm	ED cover from PNH
Horowhenua	Rostered GPs	ED cover from PNH
Otaki	Rostered GPs Kapiti Medical A&M	Kapiti Medical A&M ED cover from PNH

2.3 Emergency Department at Palmerston North Hospital

MidCentral Health, the provider division of MidCentral DHB, has contracts with GPs to provide after hours cover for the period 11pm at night to 8am. GPs fund this service. The Emergency Department receives telephone calls and also drop in visits.

2.4 Pharmacy services

The effectiveness of an after hours primary health care service is reduced if there is no access to pharmaceuticals. Where there are scheduled after hours clinics, pharmacies will often open. Where GPs are working off a roster this is less likely to occur. In Levin there is no after hours

pharmacy service. The DHB has organised for GPs to access the Medical Practitioner Supply Order which enables them to carry a range of common medicines from which they can dispense.

2.5 Radiology

After hours radiology services are generally not available within the district except through Palmerston North Hospital. City Doctors in Palmerston North has radiology services available during its opening hours and Radius Medical has an oncall service which it very seldom uses. In general patients requiring radiology out of hours are referred to the Emergency Department at Palmerston North Hospital.

2.6 Dannevirke Nurse Triage Service

The Dannevirke nursing triage service was established in 2001 as an innovative way of relieving the pressure of after hours duty on Dannevirke GPs. The service is provided from Dannevirke Community Hospital and was initially funded by the DHB from Referred Services Savings earned by Dannevirke GPs.

At the close of business, general practice phones are switched over to the hospital. Any call from a patient after hours is answered by one of the hospital nurses. The nurses have been trained for the role. Calls are triaged according to protocols and guidelines developed in conjunction with the GPs. Patients may be advised to wait until normal hours or to call an ambulance. In some instances a GP will be called. The service significantly reduces GP call outs. The strengths of the service is that it is well integrated with local general practice, the service knows which GPs are on call within the district and how to contact them, and the service is very economical because it is a marginal cost on the 24/7 nursing workforce at the hospital.

2.7 Telephone Triage

Healthline, the national telephone triage service funded by the Ministry of Health, is accessible within the district. The service is contacted via an 0800 number. Patients are triaged by trained nurses according to well developed protocols and guidelines and advised to either call an ambulance or to wait until normal working hours.

There is also a child health service associated with HealthLine.

Healthline is not well integrated with general practice in the district. In the past it has not been promoted by general practice. The service is seen as having some limitations. In particular, it works off a separate telephone number that patients have to ring and there is no connection with local general practice or awareness of service availability locally.

There are other telephone triage options available. One of these is the Procare system.

2.8 Managing Transitions in Arrangements

In some practices telephones are switched over so any calls after hours are automatically forwarded to the after hours provider. As a result, with one call the patient contacts the after hours service provider. In other cases, practices have voice messages telling the patient who to contact. This results in a multi-step process for the patient and is a barrier to access.

2.9 Ambulance services

Ambulance services are a very important part of the after hours primary health care service. St John is the provider of ambulance services across the district. The service is bulk funded by the Ministry and contracted on a fee for service basis by ACC. The service relies heavily on community donations and volunteer ambulance staff to support the permanent crews.

St John report that after hours calls are placing increasing strain on their ability to meet their emergency response standards. They state that the issues are similar across the district (111 and ambulance despatch being the default after hours service) but that the Horowhenua has the most significant need. St John has signalled to the Ministry that Horowhenua is a "hot spot" for continuous review and St John are seeking additional funding to add one more after hours ambulance and crew.

Patients are charged a co-payment of $45 for travel to ED and approximately $100 for travel if discharged by ED and need ambulance transport home. Often patients are not aware of these fees at the time of calling an ambulance or at the time of accepting ED staff advice to have ambulance transport home.

2.10 Palliative care services

Arohanui Hospice and the region's general practice teams have formed a palliative care partnership, supported and administered by Compass Health.

The partnership does not specifically target after hours palliative care but it does strengthen the inter working of families, general practice teams, district nurses and the hospice in the time leading up to the terminal phase such that after hours care is an extension of daytime care and support.

General practice providers are required to undertake regular education programmes with specialist palliative care services and are funded for practice and house call consultations.

As part of the palliative care partnership service, general practice teams take greater responsibility for after hours medical care of their patients, particularly in the terminal phase. If this is not possible on any given evening, then deputising to the after hours GP roster service is arranged and in this case is passed on to the Hospice after 11pm.

The service has been recognised as providing far better home based care than existed before the programme began. Anecdotally general practice providers generally provide the patient's family with personal contact numbers with a phone "anytime" approach to care and support.

2.11 District Nursing Services

MidCentral Health provides a 24/7 District Nursing Service. While after-hours District Nursing Service is not an emergency service, it requires advanced nursing expertise, liaison and co-ordination skills to assess and deliver appropriate care as often after hours back up is not readily available.

The care delivered includes:

- Assessment and Symptom management
- Medication management

After Hours Plan

- Nursing care and evening settling
- Support for patient, family and caregivers in terminal phases of disease
- Hospital in the Home patients for assessment and IV administration
- Community IV patients for administration of IV administration
- Patients discharged from Post Emergency Department Assessment & Liaison (PEDAL), for assessment and monitoring
- Complex wounds which require BD (twice daily) visits
- Catheter management including trial removal of catheter (TROC)
- Current patients with acute problems related to their health condition/disability
- Reduced staffing at all 6 bases each weekend to manage complex, high need patients generally in the above groups
- In emergency situations District Nursing liaises with GP and Emergency Department.

Referrals are accepted over the 24 hour period. At the end of 'normal business hours' the service is co-ordinated and delivered from Palmerston North across the whole DHB area.

After hours staffing:

- 1pm - 8pm - 1 Registered Nurse, 1 Enrolled Nurse
- 3pm - 11pm - 1 Registered Nurse, & Escort
- 11pm - 7am - 1 Registered Nurse, & Escort

District Nurses provide the clinical management for palliative patients in conjunction with Hospice and GP team. This includes both cancer and non-cancer conditions.

3. Issues with After Hours Services

3.1 Community Needs and Expectations

3.1.1 Geography and Demography

MidCentral District covers a wide geographical area with a population of approximately 155,000 people. Slightly less than half the population live in Palmerston North, with the remainder dispersed through provincial centres, small towns and rural communities across the district. The population profile is not consistent across the district. Within various communities there are higher proportions of 65+, Maori and high deprivation localities. Health status is similarly variable across the district.

The major communities are as follows:

Horowhenua–The Horowhenua TLA is the second largest population grouping at 19% of MidCentral District (28 989 people), with the highest proportion of Maori at 20%, and is the most socioeconomically deprived of the five TLAs. It has a significant proportion of older

people and morbidity and mortality indicators are generally significantly worse. The Horowhenua population makes high use of after hours and ambulance services.

Otaki–The smallest population cluster in MidCentral District resides in the Kapiti Coast CAUs (7 761 people). This group makes up 5% of the District's population, and comprises a large aged population reflective of retirees settling on the Coast. It is one of the furtherest communities from Palmerston North and transport is a frequent obstacle to accessing health services.

Manawatu–The Manawatu TLA makes up 18% of the District's population (26 565 people). It has low socioeconomic deprivation, and has, proportionately, a lower Maori population at 13%. The Manawatu area is large and the population is geographically spread through a number of small towns and communities.

Palmerston North City–Forty six percent of MidCentral District's population resides in the Palmerston North TLA (69 645 people).

Tararua–The Tararua TLA makes up 12% of the District's population (17 412 people), and has, proportionately, the second highest number of Maori within its population at 18%. It has some high socioeconomic deprivation but overall tends towards moderate to low deprivation. There is a significant rural population and transport can be an obstacle to accessing health services.

3.1.2 Service Access

The minimum requirement for services to be provided is stated in the Service Coverage Schedule which is part of the Operating Policy Framework within which DHBs operate. It states that 95% of the population should be able to access after hours medical care within 60 minutes. Technically, this requirement can be met by providing after hours services only in Palmerston North. But community expectation is now such that direct access to local GP services is expected outside of normal business hours and at a minimum in the Horowhenua there is community demand for more personal triage services after hours.

3.1.3 Community Expectations

After hours services have been a source of considerable concern to some communities, particularly to those in the Horowhenua. There are two common themes that emerge reflecting expectations that communities have of after hours services:

Services will be accessible

Smaller communities are generally tolerant of the need to achieve a compromise between GP availability and accessibility of services. They appreciate that this usually means the need to travel for care after hours. Larger communities, Levin in particular, have an expectation that care will be available locally. This is particularly because of transport problems associated with accessing Palmerston North Hospital. People do not mind accessing hospital services in Palmerston North after hours where there is a medical need to do so, but in those instances where the patient is assessed and does not require care, dissatisfaction arises because of the transport issue. Particularly where the patient is transported to hospital by ambulance. The patient pays $40 for the

ambulance trip to Palmerston North Hospital (unless it's ACC) but the ambulance does not take them back or if it does, it is at considerable expense to the patient. This has been a recurring issue for Levin.

Services will be transparent

The second issue that often arises for communities is the need for clarity about what after hour services are available and how they are to be accessed. This information needs to be readily available, up to date and easily understood by people who are looking for it outside of normal working hours and sometimes in circumstances that involve quite a lot of stress. Clarity in after hours arrangements can be achieved most easily where services are accessed through a single and constant point of contact (eg, a specific telephone number) or through the same access points as are used for routine weekday care (eg, by ringing your own general practice team). Difficulties can occur when multiple steps are required to access care – for example, where an answerphone directs a patient to another number which advises them of the services available.

3.2 Workforce Issues

3.2.1 General Practitioners

Historically after hours care has been provided almost exclusively by General Practitioners. In recent years the GP workforce changed in a number of ways. The overall number of GPs within the district has reduced significantly meaning on call obligations have increased. Practices also face greater pressure in terms of larger patient registers, for example resulting in reduced availability of "acute" or walk in appointments during the day. This also translates into more demand for after hours care, both within the primary health care setting and also the Emergency Department. In other districts practices have found that providing more acute walk in appointment opportunities during normal working hours reduces after hours call outs significantly. Some practices in the MidCentral district also reported that holding regular after hours clinics (eg, Saturday afternoon) for drop in patients reduced after hours call outs.

There are also a significant number of people within the district who are not able to, or chose not to, enrol with a general practice team. These people appear more likely to use after hours services for primary health care needs.

Other important changes are occurring in the GP workforce. Overall the workforce is ageing. New GPs are more likely to be women and more likely to be working part time. In some cases there are security issues associated with GPs working on their own after hours. There are also more GPs working in salaried positions. Overall GPs are increasingly unwilling to provide after hours services, particularly where there is an expectation that they will provide their full normal day time service and night time cover as well. Pressures on the number of GPs varies across the district and is cyclic.

For the reasons outlined above, the proportion of GPs participating in after hours cover is dropping. This is placing an increasing burden on those who do. A significant number of GPs are now unable to participate in after hours services for various reasons or simply refuse to do so. This raises very real equity issues between GPs that undermine the entire after hours service. This is particularly the case given that by and large, after hours cover is still worked out between GPs on a collegial basis.

For after hours services to work, the burden of providing cover needs to be equitably spread between individuals. If it is not possible to do this, other mechanisms need to be found to balance things out. This might include, for example, compensation. This needs to be addressed through the back-to-back contracts GPs hold with their PHO. What-ever route is taken, in future PHOs need to have a more active role in organising after hours arrangements to take some of the pressure that the current system places on relationships between clinical staff.

The trends in the GP workforce noted above will continue. A recent NZIER report on the impacts of demographic change on the demand and supply of the health workforce indicates that the age adjusted supply of GPs per capita is likely to decrease substantially rather than increase. One implication is that health providers will need to find alternate ways of managing demand for primary care services, including:

- Use of advanced practitioners (nurses, allied health)
- Use of email and telephone consultations for reassurance/advice
- Supporting use of self care
- Better chronic care management and delegation of management of medical conditions such as diabetes and CVD to nursing / allied health professionals.

It is likely that a portion of current GP work could be done through nursing services or other advanced practitioners. NHS evaluations of minor injury clinics or nurse led walk in clinics show some affect on ED volumes and GP after hours volumes, (although these services seem to often serve patients who would otherwise not present – perhaps replacing self care). Patterns of primary care use of nursing services are adapting to the new partially capitated model, but it may take some time before both patients and GPs are comfortable making fuller utilisation of the skills of nurses and allied health practitioners in a team approach.

3.2.2 Other professional groups

Other professional groups are affected by some of the trends in the GP workforce although to a lesser extent. Primary health care nurses are also aging but the workforce is larger and somewhat easier to develop than GPs. There is considerable potential to use other professional groups to support after hours services. Nursing and paramedics stand out as the key possibilities.

3.3 Emergency Department Issues

Attendances at the Emergency Department at Palmerston North Hospital have increased significantly in recent years and the Department is experiencing difficulty managing the workload. Staffing and physical resources are both constrained. Anicdotally many of the people attending the Emergency Department could be appropriately cared for in the general practice environment. Work is underway reviewing Emergency Department data which will be the basis of an informed view but there appear on the surface to be a number of issues:

- Some of the attendances relate to the fact that Emergency Department services are free whereas general practice attendances, especially after hours attendances, are not. This provides an incentive for people to use the Emergency Department. The disadvantage of using the Emergency Department is longer wait times. For some population groups, cost factors are more important than time.

- The move to PHOs and capitation funding of general practice combined with declining GP numbers means there is a pool of people who are not enrolled with a general practice. These people are more likely to access the Emergency Department for their care. In this way the Emergency Department is providing a substitute primary care service. This client group is more likely to be from deprived areas and is also likely to have greater health needs. Restricting access to ED services runs the risk of denying these individuals access to necessary clinical treatment, if they do not use primary medical services as an alternative. At the same time however, the Emergency Department is not designed to deliver primary care services. The emergency department is not equipped to provide follow up and continuity of care for chronic diseases, nor to establish a long term relationship with a patient or their family.
- The increasing workload on general practices means patients may not be able to access urgent appointments which might prevent Emergency Department attendances. Within Palmerston North, practices often refer patients to City Doctors for urgent appointments, but sometimes this service is also over committed. In these circumstances patients are more likely to present at Emergency Department.
- The business of general practices also means that GPs are more likely to refer patients with significant and complex health needs to the Emergency Department because they do not have the time and resources to manage their care in the practice.

There are a variety of strategies that could be used to address the needs of the vulnerable population using ED services as a substitute primary care service. The goal of such strategies would be to link people into primary care services that are accessible and affordable for them, and hence to reduce dependence on ED. Potential strategies include:

- Identification of the PHO enrolment status of ED attendees, and proactive linking to PHOs for those not enrolled
- Referral of low income families using ED to PHOs who may have SIA funding or services to provide low cost primary care services at least for a period of time
- Linkage to income and social support agencies through appropriate staff and/ or access to information in ED / after hours services.
- Provision of hardship subsidies to allow free A&M consults for those in need – as an alternative to visiting ED.

The key to implementing any of these approaches would be a closer working relationship between ED, A&M clinics and PHOs and the use of an ED attendance as a trigger to ensure people are appropriately enrolled and linked in to necessary supports in the primary/community sector. A further critical success factor is investment in targeted services, practices and in PHO infrastructure so that low cost access and care coordination is available to those that require it.

3.4 Funding of After Hours Care

Current funding for after hours care is a combination of patient charges and capitation funding from the DHB. The DHB also provides direct funding for a small number of services that are related to after hours care. For example, the Tararua nurse triage service. The DHB also subsidises the 11pm to 8am Emergency Department cover arrangement.

General practices receive capitation funding from the DHB (via the PHOs) on the basis of the people enrolled on their patient register. Capitation funding combined with patient charges is expected to meet the **total health care needs** of the patient. The capitation funding formula is nationally consistent and assumes a certain number of visits by the patient to a general practice team each year. Some of these visits will be out of hours. In this way capitation funding is deemed by the Ministry of Health to include the cost of after hours care, although the Ministry has not provided details of the weighting provided for after hours care or the contribution after hours care makes to the total capitation price.

Capitation funding is about the total health care of the patient. There are a number of reasons why this is an imperfect way to fund after hours care. Firstly, it assumes that all GPs are contributing equally to the after hours service. If this is not the case, a GP who does participate is essentially subsidising a GP who does not. Secondly, the capitation funding model does not sit very comfortably with Accident & Medical services which by definition see a high proportion of other GPs' patients. Some of these issues arise because the PHO pays the entirety of capitation funding to the GP with whom the patient is enrolled but then does not enforce the obligation to provide the full 24/7 service. The options are either to enforce the obligation to provide after hours contribution or to withhold a portion of the capitation funding to redirect it to those GPs who do provide the service.

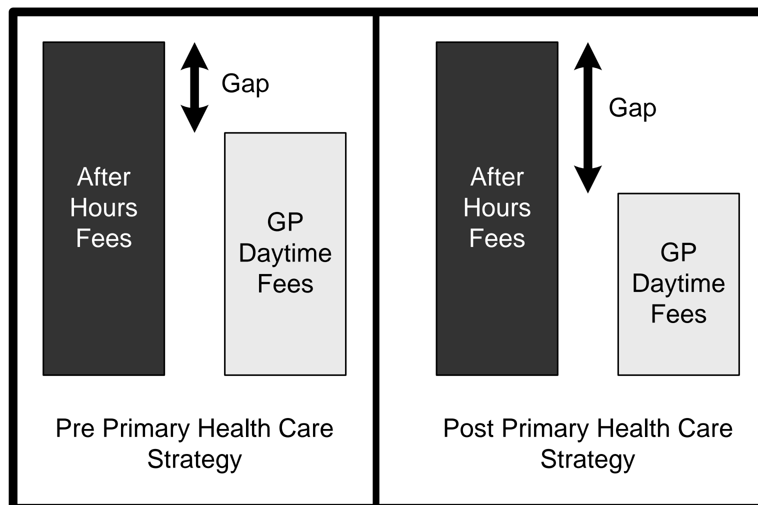
Generally, attendance rates at A&M services have dropped and are not sufficient to sustain these services beyond 9pm or 10pm at night, even in Palmerston North. The Palmerston North situation is complicated by the presence of two A&M services operating from different facilities, both of which report financial viability issues. The level of cooperation between the services is less than optimal due to an inability to move past historical issues.

3.5 Affordability of After Hours Care

The Government has invested considerable funding over the last three years to reduce patient charges. As a result, all enrolled patients now receive reduced cost attendances at general practice. The reduced fees apply only to care provided within normal working hours. After hours care has not been affected by the increased funding and in fact after hours costs have generally increased. The gap between after hours and daytime primary care fees has increased and there are concerns about the affordability of after hours care. It is likely that the increased differential between after hours GP fees and daytime fees (figure 1) is a major contributor to the drop in after hours medical attendances at primary care centres, and the increase in ED attendances After Hours.

The district also has examples at the other end of the scale where the differential is too small and creating patient expectation of a level of local after hours care that can not be sustained on the fees charged.

Figure 2: GP/After hours fee differentials: ***As GP fee's become more subsidised there becomes a marked fee differential in between primary care fees and after hours centre fees, making a visit to ED a more attractive option***



It would be sensible to have within the district agreement on an appropriate differential on after hours fees. This would need to be accompanied by an agreement to cross subsidising from normal hours to after hours and may require an adjustment in normal hours fees in some cases. The ratio of day time to after hours attendances is such that a reasonably small adjustment would be required.

4. A Sustainable After Hours Model for MidCentral District

4.1 Principles of a Sustainable Service

Accessible after hours services:

- are available 24 hours a day, seven days a week (24/7) within reasonable travel times
- are affordable to the communities they serve and do not have unreasonable cost barriers
- are acceptable and informative to patients so they know where to go and what co payments they can expect to pay.

Effective after hours services demonstrate:

- continuity of care – in most models of after hours service delivery it is common for the patient to see a general practitioner (GP) or nurse who is not their regular health professional, which places greater importance on the efficient transfer of information between providers and on management systems that support this transfer
- co-ordinated care that is well linked in with other key services such as ambulances, the ED, social support, laboratory services, imaging/radiology and pharmacy services

- teamwork so that the competencies of the primary health care team are well utilised safely for both patients and providers.

Resilient after hours services:

- are sustainable over the long term in terms of workforce by making appropriate use of skillsets and not placing unreasonable demands on staff, and able to recruit and retain a sufficient, competent workforce
- are funded at an appropriate level from all sources, including patient co-payments, to maintain the service
- are capable (right competence, right time, right place)
- make efficient use of resources (workforce, facilities, technology etc) to achieve the best outcomes for least cost.

Planning for accessible, effective and resilient after hours primary health care should also be congruent with the key directions of the Primary Health Care Strategy and with He Korowai Oranga: Mäori Health Strategy which sets a new direction for Mäori health development, building on the gains made over the past decade.

In the future PHOs need to have a more active role in organising afterhours arrangements to take some of the pressure that the current system places on relationships between clinical staff.

- One implication is that health providers need to find innovative ways of managing demand for primary care services including:
- Use of advances practitioners (nurses, allied health)
- Use of email and telephone consultations for reassurance and advice
- Supporting the use of self care
- Better chronic condition management and delegation of the management of medical conditions such as diabetes and CVD to nursing/allied helath professionals

5. Proposed Model for MDHB

5.1 District Wide Vision

The preferred vision for after hours services is that primary health care, ED and other relevant services work together on a sustainable basis so that people:

- Know where to go/who to call to get appropriate services
- Use urgent after hours services for urgent conditions – not as convenience medicine
- Are seen in the most appropriate setting by the most appropriate person (those that need nursing services see a nurse, those that need primary care services receive them, and those that need emergency services receive them)
- Do not go without essential services because of cost

- Are supported to treat themselves where appropriate (self care advice)
- Are treated by well prepared proactive teams
- Receive high quality, coordinated services.
- Receive services that are reasonable in terms of the burden they place on individual health professionals and in doing so are sustainable in the use of the available workforce.

5.2 Model

The following model presents the basis for after hours primary health care services in the district.

- During normal business hours services are to be provided by regular general practices, with back up from the A&M clinics as needed.
- The period from 5pm to 9pm weekdays should be covered by local clinics. This is the period of most significant demand for services.
- From 9pm to 11pm telephone triage services will be the first port of call, with A&M centres in Palmerston North providing for face to face service.
- From 11pm to 8am the Emergency Department at Palmerston North Hospital will cover.

During the weekends there should be scheduled clinics in each PHO area provided by local practices.

<table>
<tr><th colspan="12">AM</th><th colspan="12">PM</th></tr>
<tr><td>12</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td></tr>
<tr><td colspan="8" rowspan="2">MidCentral Health ED
Potentially some patients may be referred to:
Capital and Coast ED
Wairarapa ED
Hawkes Bay ED</td><td colspan="10" rowspan="2">Normal General Practice Surgeries</td><td colspan="3">Local Clinic Rosters</td><td></td><td colspan="2">Health Line</td></tr>
<tr><td colspan="6">After Hours Clinics:
- City Doctors
- Radius
- Kapiti Medical Centre
- Waipukerau
- Wairarapa</td></tr>
</table>

5.3 Elements of the After Hours Service

5.3.1 Triage Services

The national MoH Health Line service is already functioning and provides triage support for patients within the MidCentral district. It does not cover the complexity of referencing after hours telephone support for locally based GP rosters. To use Health Line effectively would require a common after hours telephone number and system across the district.

ProCare provides an alternative telephone triage and general practice telephone answering service on a subscription basis. It has the advantage of being tailored to suit specific practices and

specific localities. It is well regarded in other districts. For example, Kapiti GPs are using the ProCare service.

5.3.2 Telephone Services

Telephone services to patients are fragmented across the district with each practice, groups of practices, after hours clinic and ED having separate telephone services, often using a variety of answering systems and providers.

For example a Horowhenua patient may ring their local GP after 11pm. The practice answering machine message may refer them to the doctor on call, who may in turn refer them to City Doctors, whose answering service would refer the patient to ED. The complexity of when practices and City Doctors switch their telephone services to the next provider should be rationalised. There is modern technology available that can manage this process in a seamless fashion. Rationalisation will make patient communication and roster management easier and will go a long way to addressing community concerns about after hours services.

Bothe triage and communication issues have been improved in other DHB districts through the use of Healthline. GPs in the Wairarapa report significantly reduced after hours calls with the introduction of Healthline.

5.3.3 Emergency Department cover

The 11pm to 8am cover provided by the Emergency Department at Palmerston North Hospital is highly valued by GPs and is workable for the Emergency Department. In the past GPs have funded the service directly by way of payment of invoices from MidCentral Health. This aspect of the arrangement has significant transaction costs and has also created friction. It has been proposed that in future PHOs assume responsibility for funding MidCentral Health for this service, and that the funding be obtained by top slicing capitation funding. The overall level of funding required is minimal when considered on a per patient basis (less than $1 a year).

The GPs would strongly prefer that Emergency Department cover commence at 8.00pm or 9pm however the Emergency Department cannot accommodate this because of limitations on workforce and space. Statistics show that the Emergency Department is still busy in the 9pm to 10pm period. It would be unreasonable for primary care to not acknowledge this fact.

In the course of developing this Plan, GPs have offered assistance to the Emergency Department to manage its workload. Specifically, by providing GP management of primary care patients, possibly through a collocated service. This is consistent with current directions in a number of places nationally, including Wellington, Wanganui and Dunedin. In addition, general practice can also assist through better management of acute patients in general practice settings. This issue is not specific to after hours and is being considered through the separate Emergency Services project.

5.3.4 Funding Arrangements

After hours services should continue to be funded from a mixture of capitation funding and patient charge. Patient charges should be based on a differential on normal charges so that they are affordable while still incentivising people to use normal weekday services. This involves cross subsidisation from normal weekday care to after hours care. This will only be effective if all GPs are participating in after hours care. Given that this is not the case, the PHOs need to devise a way of giving effect to cross subsidisation.

PHOs also need to devise a more equitable way of distributing capitation funding so that it supports after hours care.

Overall PHOs need to assume a more active role in organising after hours care within their area. This includes organising cover arrangements. PHOs also need to take a lead role in ensuring that after hours arrangements are reasonable and effective. Historically GPs have organised after hours rosters and services on a collegial basis, however, this is becoming increasingly difficult for a variety of reasons. PHOs, through their back to back contracts with providers, have the ability to establish a framework that supports the collegial approach.

The DHB should give consideration to supporting infrastructure development around after hours services. For example, through improvements to telephone communications, information systems, the implementation of telephone triage systems throughout the district, and consolidation of after hours services around specific facilities within local areas.

5.3.5 Ambulance / Emergency Medical Response Services

Ambulance services are provided across the MidCentral district on a 24/7 basis by St Johns. Currently the level of service is narrowly defined and restricted to triage and transport. There is potential for ambulance services to provide a higher level of service within communities, but this will need to be funded outside of the existing Ambulance contract. Aside from funding issues, there are also concerns about scope of practice, clinical support and training, and accountability that would need to be worked out.

5.3.6 Pharmacy

Pharmacy is an essential part of the health care system. It is important to have access to pharmaceuticals after hours to support general practice. This is an issue particularly for Levin. The DHB has organised for Horowhenua GPs to access the Medical Practitioners Supply Order which enables them to carry a range of common medicines from which they can dispense.

5.3.7 Community Awareness

A key element of effective after hours care is that the community be fully aware of the services available and how they are to be accessed. This includes an understanding of the levels of care that are available at various times of the day. Of particular importance is an appreciation that the purpose of after hours services is *to meet the needs of patients that cannot be safely deferred until regular or local general practice services are next available.*

It is therefore important that there are consistent messages to communities including, for example, regular notices in community newspapers/newsletters on after hours access. It is critical that community expectation is consistent with the service levels that are operationally, financially and contractually sustainable.

5.4 Achieving the Vision District Wide

The key elements of a strategy to move towards the vision are set out below:

1. **A sustainable workforce** is achieved by a pro-active consolidation of services across the district, offering local medical services 8.00am-8.00pm and PNth based services 8.00pm-8.00am. Nurse triage and treatment options will be explored as to how they may support enhanced local access each evening.

2. **Patients seen at the appropriate level:** transfer as many as possible of the 'primary care' appropriate patients from ED to after hours or day time primary care services

3. **Communication/information:** invest in ongoing strategies to inform people of their options and to help them make appropriate choices this may include promoting self care and Healthline.

4. **Overnight:** duplicating overnight services for the small number of patients that present between 11pm and 8am is not a good use of resources. The current overnight Cover service based at PNth ED will be retained. However GPs should provide their own overnight care for palliative care patients in conjunction with palliative care services wherever possible.

5. **Make after hours primary care more affordable but retain significant differential between day and night to provide right incentive:** reduce the differential between primary care after hours and day time fees by subsidising after hours care. This can be achieved by increasing day time fees or by new investment.

6. **Hardship fund:** if some people need free urgent primary care then this should be available in the primary care after hours services as well as at ED.

7. **Promote nurse triage service and the national Healthline:** research suggests that encouraging people to call Healthline before going to the after hours or ED service is likely to reduce inappropriate demand for after hours services. Local triage and nurse or paramedic treatment services may also add another dimension.

8. **Use of nurse/advanced practitioner resources:** fund services in a manner that explicitly encourages better use of nursing and allied health staff at after hours services.

9. **Support self-care**

10. **ED/after hours/ambulance/district nursing liaison:** promote closer working relationships between ED & after hours primary care services and between these two services and the ambulance and district nursing services.

11. **ED redevelopment planning** will include GP participants to explore future co-location and integration options.

12. **Daytime access**: encourage PHOs to work with practices to ensure same day appointments are available.

13. **Transport subsidies after hours**

14. **Standing orders** and daytime arrangements with residential facilities to be reviewed and expanded

15. **Palliative care:** ensure that palliative care planning covers both daytime and after hours access to home based services, including primary medical services across the district.

6. Appendix 1 - Notes from a meeting held on November 6th 2006 After Hours meeting

Issues and possible solutions

An initial meeting was brokered by the district's PHOs to identify district wide and location specific after hours issues and potential solutions. The meeting was attended by GPs, practice managers, PHO Managers, MidCentral Funding and Planning Division, MidCentral Health GP Liaison and MidCentral ED.

	Common Issue or Factor that is Working Well	**Comment**	**Potential Plan Action**
✓	ED services 11PM through 8AM	▪ Not all GPs paying agreed amount to MidCentral Health ▪ Not all GPs taking advantage of the services ▪ GPs would like ED coverage to begin at 9pm but ED has capacity constraints (space and workforce)	▪ Simplify payment mechanism through PHOs by top-slicing capitation payments ▪ Ensure service is available to all GPs in the District Work with ED to identify any potential solutions.
✓ ✗	Clarity and simplicity of after hours cover	▪ Community confidence in after hours services is based on: o Clarity about what the arrangements are o Ease of access – preferably local. ▪ Poor coverage of after hours care from 8pm through 11pm	▪ Communicate arrangements to community ▪ Use communications systems & the like to achieve seamless transfer at hand over points ▪ City Doctors to be used for evening cover. **These arrangements are in place.** o 35 GPs from Palmerston North participate in City Doctors roster, providing cover from 5:30pm through 11pm weekdays and weekends 8:30am through 11pm o Tararua, Dannevirke: Saturday afternoon and evening until 11pm and Sunday 8:30am through 11pm. o Horowhenua: Weeknights 8pm until 11pm and from 7pm to 11pm weekends ▪ Dr Jonathon Morton (practicing at Radius, The Palms, provides cover for: o Pahiatua 5pm through 8am seven days per week (no ED arrangement) o Drs Stephen Liaw and John Geard 9pm to 11pm o Dr Nelson Nagoor 6pm to 11pm

	Common Issue or Factor that is Working Well	Comment	Potential Plan Action
✓	Weekend and evening clinics	▪ Regular scheduled evening and weekend clinics seem to be effective in reducing demand for on-call.	▪ Greater reliance on scheduled after hours clinics in each community. ▪ Fees set so as to reinforce appropriate use of services.
✘	Equity in after hours obligations	▪ Distribution of after hours workload between GPs (& others) needs to be equitable if cover is to be sustainable. ▪ Some GPs are unable or unwilling to participate in rosters.	▪ Clarify expectations in contracts. ▪ PHOs to take more active role in organising after hours arrangements. ▪ Provide an opt-out option for those who can't participate in rosters.
✘	Pressure on local rosters	▪ Otaki, Horowhenua and Tararua Rosters have pressures on them o Insufficient GPs for cover o GPs living outside the PHO area o Telephone systems largely manually managed (exception Otaki) ▪ High patient load weekend clinics in Horowhenua ▪ Personal security ▪ Cover for house calls after hours ▪ Patients behaviour is normalised to not put pressure on after-hours system	▪ Improve rosters through better organisation of effort – eg, rosters shared across wider groups ▪ Move to a three tiered service o Local GP clinic (to 8PM) o After-hours service provider (e.g. City Docs/Radius) 8PM to 11PM o ED after 11PM ▪ Common telephone answering systems with nurse triage at community health centre/hospitals ▪ Clarify provider's obligations in contracts and make provision for "buy out" and contract in replacement resource. ▪ Investigate using fixed clinics (eg, community health centres) for after hours services because of better security, etc, and accessibility. o Is this workable? Desirable? o Remote access to Practice Management System to allow GPs to handle paperwork when no patients presenting ▪ Transport is a significant issue for patients. review: o Existing costs o Possible transport subsidies
✘	Unavailability of lab, radiology and pharmacy services	▪ Applies to Otaki, Feilding, Horowhenua and Tararua ▪ Lack of pharmacy often resulting in immediate advice to patient to go to PN or Kapiti.	▪ Ensure local pharmacy available when regular after hours clinics held. ▪ Rural scheme drug holding
✘	High number of patients being referred directly to ED by ambulance	▪ Horowhenua has (anecdotally) very high ambulance service use per head of population	▪ Review ambulance data for region ▪ Investigate ambulance contract change – transport AND paramedic frontline care?

	Common Issue or Factor that is Working Well	Comment	Potential Plan Action
✘	Community expectations of local GP availability 24/7*	There is a tendency to use after-hours services for routine care (for convenience reasons). This is not sustainable within the resources available. After hours care needs to be for urgent care.	▪ Communication/education component for communities about appropriate use. ▪ Patient fees should be set to change non-emergency use of clinics and after-hours call outs.

7. Appendix 2 - Attendance at ED

All Attendances at PN ED between 22:00 and 8:00 for the 12 month period between 01 Nov 2005 and 31 Oct 2006

DHB	TERRITORIAL AUTH NAME	Admitted	Not Admitted	Grand Total
Midcentral DHB	Palmerston North City	725	3889	4614
	Horowhenua District	385	809	1194
	Manawatu District	183	773	956
	Tararua District	155	357	512
	Kapiti Coast District	59	110	169
Whanganui DHB	Rangitikei District	60	183	243
	Wanganui District	19	32	51
	Ruapehu District	4	14	18
Capital and Coast DHB	Wellington City	5	51	56
	Kapiti Coast District	10	17	27
	Porirua City	2	16	18
Hawkes Bay DHB	Napier City	3	25	28
	Hastings District	7	16	23
	Central Hawke's Bay District	2	8	10
	Wairoa District		1	1
Hutt DHB	Lower Hutt City	6	19	25
	Upper Hutt City	3	12	15
Taranaki DHB	New Plymouth District	2	16	18
	South Taranaki District	2	12	14
	Stratford District	1	3	4
Overseas resident	Overseas resident	5	24	29
Waikato DHB	Hamilton City	1	14	15
	Waipa District	1	2	3
	Waitomo District		2	2
	Matamata-Piako District		2	2
	Ruapehu District		2	2
	South Waikato District	1	1	2
	Hauraki District	1	1	2
	Thames-Coromandel District		1	1
Auckland DHB	Auckland City	2	20	22
Lakes DHB	Taupo District	2	9	11
	Rotorua District	1	9	10
Counties Manakau DHB	Manukau City	2	6	8
	Papakura District		7	7
	Franklin District	1	4	5
Waitemata DHB	Waitakere City	4	11	15
	North Shore City		2	2
	Rodney District		2	2
Unknown	Unknown	2	13	15
Bay of Plenty DHB	Tauranga District		9	9
	Whakatane District		4	4
	Opotiki District		2	2
Wairarapa DHB	Masterton District	1	11	12
	Carterton District		2	2
	South Wairarapa District		1	1
Northland DHB	Far North District		7	7
	Whangarei District	1	2	3

DHB	TERRITORIAL AUTH NAME	Admitted	Not Admitted	Grand Total
	Kaipara District		2	2
Canterbury DHB	Christchurch City	3	6	9
	Selwyn District		2	2
	Waimakariri District		1	1
Sth Canterbury DHB	Timaru District	2	4	6
Otago DHB	Dunedin City	1	2	3
	Central Otago District		2	2
	Waitaki District		1	1
Southland DHB	Invercargill City	1	1	2
	Gore District		2	2
	Queenstown-Lakes District	1		1
Nelson Marlborough DHB	Nelson City	1	2	3
	Marlborough District	1	1	2
Tairawhiti	Gisborne District		3	3
Grand Total		**1668**	**6562**	**8230**