HEALTH POLICY ANALYSIS

Commonwealth Department of Health

Evaluation of PHN After Hours Program

Volume 3: Case studies

Revision history

Version	Date	Modifications
0.1	30 November 2020	Initial draft.
0.2	22 December 2020	HPA edit of initial draft.
0.3	14 January 2021	Final edits

Suggested citation

Health Policy Analysis 2020, Evaluation of PHN After Hours Program, Volume 3 Case studies, Commonwealth Department of Health, Canberra.

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
AH	After hours
CALD	Culturally and linguistically diverse
ED	Emergency department
GP	General practitioner
HNECC	Hunter New England and Central Coast
HPA	Health Policy Analysis
LETSS	Lived Experience Telephone Support Service
LGA	Local Government Area
LHD	Local Health District (NSW)
LHN	Local Hospital Network
MBS	Medical Benefits Schedule
MDS	Medical Deputising Service
MMM	Modified Monash Model
NGO	Non-Government Organisation
NSW	New South Wales
PHN	Primary Health Network
PHT	Primary Health Tasmania
PIP	Practice Incentive Program
RACF	Residential aged care facilities
SA	South Australia
VMO	Visiting medical officer

1 Key observations from the case studies

Box 1 below summarises the key observations from the eight case studies undertaken for the evaluation of the PHN After Hours Program.

Box 1 – Case study key observations

CS1 Eastern Melbourne

- Stakeholders noted a **growth in demand** for after-hours services associated with **population growth** in certain areas.
- In some instances, there appeared to be **limited trust in after-hours care options** beyond the ED.
- The 12-month program funding cycles and general uncertainty about the future of the program impacted the PHN's ability to:
- plan effectively
- co-commission and co-design after-hours activities, and
- commission larger-scale projects that may have had a broader impact on the PHN population.
- It is difficult for PHNs to attribute the extent to which after-hours services reduce ED demand.
- **Recruiting GPs and other health professionals to work after hours was an ongoing challenge** in the region and had become more difficult with changes to both the eligibility for MBS after-hours items and the recruitment of overseas doctors.
- **Collaboration, service integration and information sharing were continuing challenges** for stakeholders, and there are opportunities to improve these across the health system.

CS2 Brisbane South

- **There can be after-hours service gaps in metropolitan PHNs even where supply of after-hours GP clinics is appropriate for the majority of the population**. Jimboomba, in the Brisbane South PHN, was not well supported in the after-hours period and distance and travel times were a significant barrier to an MDS being established and sustained.
- The MDS was not able to engage in direct consumer advertising in line with the Department of Health guidance. The MDS can promote the service to GP practices and this formed part of the 13SICK's engagement plan. The restrictions in promoting and increasing awareness appeared to limit the growth and usage of the MDS. Services of this nature, particularly in the establishment phases, **need to be supported by strategies to work closely with general practices, service providers and others** so that consumers are able to access care and the after-hours services are well integrated with general practice.

CS3 Perth South

- **There can be after-hours service gaps in metropolitan PHNs even where supply of after-hours GP clinics is appropriate for the majority of the population**. Like many other major cities, Perth South PHN identified the homeless population as having a high need for primary care services and a group that are intensive users of ED and hospital services.
- The after-hours support service commissioned under the After Hours Program is a small element of a much larger 'housing first' initiative that includes a homeless healthcare service. The service is delivered to the very highest-need group of homeless people with significant health issues. **The service represents a significant investment from Perth South PHN to a relatively small but high-need group.**
- Mainstream services are not designed to meet the needs of some patients and **distinctions between in-hours and after-hours mean very little for some vulnerable groups.** More flexible and responsive approaches are needed.
- The success of this after-hours support service is built on a broader initiative that has brought together agencies from across the charitable, state, health and other sectors. **Strong relationships, collaboration and effective joint work are important prerequisites, as is the need for PHNs to be effective commissioners. Using the program to link and extend the existing homelessness services into the after-hours period has been very beneficial.**

- **There are often critical ingredients that come together to deliver good outcomes.** As well as the effective multi-agency work, there were key individuals who influenced and championed the needs of this client group as well as a charitable organisation that was willing to take on the 'backbone' role.

CS4 Adelaide

- While the Adelaide PHN was relatively well served by GPs in the after-hours period, the needs analysis identified **significant gaps in primary care to effectively support people with mental health issues**. These gaps existed in both the in-hours and after-hours periods.
- LETSS is providing an effective model of care that appears to be **meeting an unmet need** that sits between acute care, crisis care, other call centres and more traditional primary health care. While the Adelaide PHN was relatively well served by GPs in the after-hours period, the needs analysis identified **significant gaps in primary care to effectively support people with mental health issues**. These gaps existed in both the in-hours and after-hours periods.
- The LETSS service addresses a gap in service after hours and **contributes to the development of a stepped model of primary care** for people with mental health needs living in the Adelaide PHN region.
- Critical success factors for the LETSS include:
  - A trained, paid, peer workforce with lived experience
  - A focus on non-crisis needs, including service links and informal counselling
  - Strong relationships to escalate to and receive referral from crisis support services
  - No referral or appointment required, with minimal waiting time
  - Unlimited access, with no time or contact limit.
- LETSS volumes have grown and **the service is considered by callers and referrers as being effective** in meeting client need. The service reported that it **is operating at full capacity**. Stakeholders expressed a desire to have LETTS:
  - extend its existing after-hours operating hours
  - expand and provide an in-hours service
  - expand to provide services in Country SA PHN.
- **Few callers (3%) reported that they would have attended the hospital**, called an **ambulance or visited a GP** if LETSS was not available.
- LETSS is providing an effective model of care that appears to be **meeting an unmet need** that sits between acute care, crisis care, other call centres and more traditional primary health care.

CS5 Hunter New England and Central Coast (HNECC)

- GP Access enjoys **a high degree of trust and support** from other providers and the broader community, with key stakeholders emphasising the strong collaboration and collegiality that exists.

- GP Access has strong **collaboration with GPs and other local providers** with participation from over 200 local GPs in the Lower Hunter region to provide the triage, tele-GP and after-hours clinics.
- GP Access is a **well-integrated** system of services providing local telephone triage and linking to tele-GP advice, co-located after-hours GP clinics, home visits and aged care providers.
- Potential exists to **expand the triage service, tele-GP and provider supports** across the PHN and linking these functions to existing after-hours clinics, home-visit services and hospital care in place locally.
- Scope exists for **further integration of GP Access and EDs**. There is potential to explore shared triage models**,** including greater promotion of GP Access telephone triage and the use of GP-led triage for all walk-in patients before attending ED.
- In discussion with patient and community representatives, there were indications that there is **confusion over the various telephone numbers for services that exist**, particularly around Healthdirect and GP Access (given the change in arrangements), but also with the recent emergence of new call-based service providers.
- The ability to actively promote the use of GP Access to the public is limited, in line with restrictions on all medical deputising services. Support is needed to help PHN **identify opportunities to increase public awareness of GP Access triage functions without fuelling unnecessary after hours care.** This could be done in conjunction with Healthdirect.
- The GP Access service is funded from a variety of sources, namely MBS reimbursement, NSW Health, out-of-pocket payments as well as the PHN After Hours Program. **The PHN receives significant additional funding** through the PHN After Hours Program to support the service contributing over half of the costs.

CS6 Tasmania

- There is **no coordinated after-hours primary care plan for Tasmania** and PHT would welcome the opportunity to work with the Tasmanian Department of Health, Ambulance Tasmania and key players to develop and implement a joint plan.
- GP Assist clearly meets a need and the **service is strongly supported** by GP organisations, the Rural Health Workforce Agency, rural GPs and the Tasmanian Department of Health. PHT regards the model delivered by GP Assist as a fundamental pillar supporting and stabilising rural general practice in Tasmania.
- Opportunity exists to **explore greater integration** of telephone triage and telehealth services provided by Healthdirect, the GP Assist service, after-hours GP clinic services, other telehealth services, Ambulance Tasmania secondary triage and ED triage. There are concerns the current arrangements are overly complex and may be generating additional risks for patients and costs in administration and duplication.
- Based on available information, preliminary calculations indicate the average cost per call to the PHT and Tasmanian Department of Health of GP Assist is about $211, excluding the cost of the Healthdirect initial call costs. There would be great value in the Tasmanian Department of Health engaging with PHT to undertake a joint and more comprehensive **cost-effectiveness evaluation** of GP Assist**.**
- Subject to the outcome of the Commonwealth Department of Health's review of the PHN After Hours Program, and confirmation of longer-term funding, it would be opportune for PHT to undertake a **review of the service** in conjunction with the Tasmanian Department of Health.
- Stakeholders raised **access issues "in hours"** as a contributing factor to after-hours demand, including limited access to bulk-billing general practice, availability of public transport and care coordination and support for people living with chronic or complex conditions.
- The **PHN receives a larger share of the After Hours Program funding** than the amount that would be allocated through the weighted population-based formula. This additional funding reflects historic support of the GP Assist service. As a result, the PHN has the 3rd highest per capita funding under the PHN After Hours Program.

CS7 Northern Queensland

- There is **complexity in filling gaps in after-hours access, especially when these exist at a micro level.** Where some limited mainstream after-hours services are available in a locality, it can be difficult to commission a service that works around existing provision and effectively targets a small number of patients in specific localities.
- Stakeholders queried whether it made more sense to **rely on the ED** when patient volume and demand for after-hours services were low.
- **Systemic workforce and recruitment issues** exist throughout the region, especially in rural and remote areas. This, coupled with a reluctance of local GPs and other health professionals to work after hours, makes it difficult to improve after-hours access throughout Northern Queensland PHN.
- Stakeholders have called for increased engagement and collaboration from Northern Queensland PHN especially regarding the design of services that consider and acknowledge **existing after-hours service arrangements**.
- **Access problems are not limited to after hours, patients also face significant barriers to in-hours primary care**. Many practices were no longer accepting new patients, which leaves individuals with limited or no access to a regular GP in certain areas. There is also a lack of bulk-billing services in Northern Queensland PHN.
- The complexities of the MBS system, and the financial incentives that a fee-for-service reimbursement model creates, make it difficult for the Northern Queensland PHN to subsidise and promote deputising or other services without running the risk of being seen to undermine competition or the livelihood of other providers.

CS8 Northern Territory

- **Prior to 2015, there were no after-hours primary care services available in Alice Springs**. Since then, a combination of the Northern Territory PHN After Hours Program funded clinics and expanded hours from one other clinic in the area has resulted in a significant improvement in access to after-hours primary health care services.
- Despite this, a **lack of bulk-billing general practices** in Alice Springs presents a significant barrier to access, even where practices provide after-hours services. This was identified is a key consideration in patients' choice to attend the ED at Alice Springs Hospital.
- There are opportunities to further **develop more collaborative and strategic partnerships** between the acute and primary health care sectors. Stakeholders considered that there were opportunities for Northern Territory PHN to be more proactive in facilitating strategic planning with respect to connecting primary and tertiary care services to enhance after-hours responses. Establishing partnerships of this nature may provide a forum to improve coordination, planning and more effective service delivery, and in time, provide opportunities for co-design and co-funded activities.
- The PHN After Hours Program **funding cycle and agreements need to be longer than one year.** This would assist greatly in planning, recruitment and retention of staff, as well as assist in addressing industrial relations challenges.

2 Introduction to the case studies

The Department of Health commissioned Health Policy Analysis (HPA) to evaluate the PHN After Hours Program. The objectives of the evaluation were to assess the extent to which:

- PHNs have achieved the objectives of the program
- the program is value for money
- data indicate the successes or lessons learned.

The evaluation report is organised into four volumes. Volume 1 summarises the key findings. Volume 2 is the main evaluation report. This volume (Volume 3) presents the findings of the eight case studies undertaken for the evaluation. These contribute to the findings presented in Volumes 1 and 2. Volume 4 contains appendices.

The case study approach

A comparative case study approach was used as one of the sources of information for the evaluation. Comparative case studies are useful for evaluating impacts of a program over time and comparing within and across contexts, particularly when there is a need to understand how the context influences program outcomes (Yin, 2014).

A list of criteria was developed to guide the selection of eight PHNs to approach as potential case studies. The aim was to reflect the diversity of PHN geography, socio-demographic profiles, size, maturity of the PHN, and range of approaches towards after hours. HNECC PHN and Primary Health Tasmania were included as two of the case studies due to their unique service models.

The criteria used to select the case studies were:

- At least one PHN that includes remote and very remote SA3s.
- At least one PHN that includes outer regional SA3s.
- At least one PHN that includes major metropolitan SA3s that have relatively high levels of socio-economic disadvantage (ABS Index of Relative Disadvantage Deciles 1-3).
- At least one PHN that includes major metropolitan SA3s that have median levels of socio-economic disadvantage (ABS Index of Relative Disadvantage Deciles 4-6).
- At least one PHN that includes major metropolitan SA3s that have low levels of socio-economic disadvantage (ABS Index of Relative Disadvantage Deciles 7-10).
- At least one PHN from each state and territory, except the Australian Capital Territory.
- Include Hunter New England and Central Coast PHN, and Primary Health Tasmania.

In March 2020, the Department of Health invited eight PHNs to participate in the evaluation as case studies. Following the PHNs' agreement to participate, HPA contacted each PHN chief executive or nominee requesting an initial discussion that would help to determine the focus of each case study.

Each case study was either geographically based (covering the entire PHN or a defined region) or program-based (exploring a specific funded project or activity). Table 1 lists the eight PHNs and indicates the focus of each case study.

Table 1 – Case study site and focus

PHN remoteness	PHN	Case study focus
Major cities	Eastern Melbourne	**Geographically based**, covering the entire PHN
	Brisbane South	**Geographically based**, covering the Jimboomba area
	Perth South	**Program-based**: 50 Lives 50 Homes After Hours service
	Adelaide	**Program-based**: Lived Experience Telephone Support Service
Regional	Hunter New England and Central Coast (HNECC)	**Program-based**: GP Access program
	Tasmania	**Program-based**: GP Assist service
Remote	Northern Queensland	**Geographically based**, covering the Tablelands and Bowen
	Northern Territory	**Geographically based**, covering Alice Springs

In addition to the initial discussion with PHNs, and the completion of a survey on the After Hours Program, the evaluation objectives for each case study was discussed with PHN staff. These interviews were particularly useful in exploring the contextual factors as well as any causal attributions influencing the PHN's response.

Structured interviews were a core component of the case studies. A range of key stakeholders were interviewed at each case study site. Interviews were conducted with:

- PHN staff
- Commissioned and other providers of after-hours services
- local GPs and general practice staff
- other primary care service providers
- consumers and members of PHN consumer advisory groups
- local hospital and/or Local Hospital Network (LHN) staff.

PHNs assisted with compiling the list of relevant stakeholders and letting them know about the evaluation. HPA then contacted the stakeholders to organise an interview.

Beyond the interviews, the case studies sourced and analysed the following additional data:

- PHN needs assessments
- Activity Work Plans from 2015–16 to 2019–20
- contract monitoring reports
- reports and reviews
- reports of any local evaluations of after-hours services undertaken
- other documents or evaluations describing the local population profile and the health economy
- analysis of surveys developed for the evaluation completed by the PHNs and commissioned providers.

Due to the COVID-19 pandemic, all interviews were conducted via video or teleconference. This was between March and July 2020. With the consent of participants, the HPA consultants recorded the interviews. Table 2 sets out the number of people interviewed by role for each case study.

Table 2 – Case studies and number of people interviewed by role

Case study site (PHN and locality)	Interviewees		
	PHN	Commissioned services	Other
CS1: Eastern Melbourne	2	7	2
CS2: Brisbane South – Jimboomba	2	3	5
CS3: Perth South – 50 Lives 50 Homes After Hours service	1	1	5
CS4: Adelaide	2	3	4
CS5: Hunter New England and Central Coast (HNECC)	2	5	5
CS6: Tasmania	6	6	14
CS7: Northern Queensland – Tablelands and Bowen	2	2	10
CS8: Northern Territory	5	5	3

Comparative after hours, health and population data

Table 3 describes the case studies and the geographical area covered by the case study. The SA3s are listed for of those case studies that focused on a specific geographical area within the PHN.

Table 3 – General description of case studies

Case study	Description	Geographical SA3 areas covered by the case study[1]
CSI	A geographically based case study focused on the entire **Eastern Melbourne PHN** region. The region covers 12 LGAs with a population of 1.45 million people.	Boroondara (20701), Manningham - West (20702), Whitehorse - West (20703), Banyule (20901), Nillumbik - Kinglake (20903), Whittlesea - Wallan (20904), Knox (21101), Manningham - East (21102), Maroondah (21103), Whitehorse - East (21104), Yarra Ranges (21105), Monash (21205)
CS2	A geographically based case study focused on Jimboomba, which is on the periphery of the **Brisbane South PHN**. The region grapples with poor coverage of after-hours services.	Jimboomba (31104)
CS3	A program-based case study focused on the 50 Lives 50 Homes Program, a service supported by the **Perth South PHN**. The program covers the whole PHN region and provides after-hours nursing and assertive outreach services for those being supported by the 50 Lives 50 Homes project.	Mandurah (50201), Armadale (50601), Belmont - Victoria Park (50602), Canning (50603), Gosnells (50604), Serpentine - Jarrahdale (50606), South Perth (50607), Cockburn (50701), Fremantle (50702), Kwinana (50703), Melville (50704), Rockingham (50705)

Case study	Description	Geographical SA3 areas covered by the case study[1]
CS4	A program-based case study focused on the Lived Experience Telephone Support Service (LETSS). The program is supported by the **Adelaide PHN** and provides after-hours mental health telehealth services, including supported service linkage and peer support to people with mental health needs living in the entire PHN region. All staff have dealt with mental health issues themselves or have 'lived experience' caring for family members experiencing mental health issues.	Adelaide City (40101), Burnside (40103), Campbelltown (SA) (40104), Norwood - Payneham - St Peters (40105), Prospect - Walkerville (40106), Unley (40107), Playford (40202), Port Adelaide - East (40203), Salisbury (40204), Tea Tree Gully (40205), Holdfast Bay (40301), Marion (40302), Mitcham (40303), Onkaparinga (40304), Charles Sturt (40401), Port Adelaide - West (40402), West Torrens (40403)
CS5	A program-based case study focused on the GP Access Program, which services the Lower Hunter region. The program is delivered by Hunter Primary Care and is supported by the Hunter New England LHD and the **HNECC PHN**. The service has five after-hours clinics that operate across the Hunter region, a call centre that triages and books patient appointments during the after-hours period, and, in certain circumstances, the service can arrange patient home visits and transport.	Lower Hunter (10601), Maitland (10602), Port Stephens (10603), Kempsey - Nambucca (10802), Inverell - Tenterfield (11002), Lake Macquarie - East (11101), Lake Macquarie - West (11102), Newcastle (11103)
CS6	A program-based cased study focused on the long-running GP Assist service supported by the Tasmanian PHN after-hours program. The service covers the whole of Tasmania with most of the funding provided by the **Tasmanian PHN**. GP Assist receives calls triaged by Healthdirect Australia as needing to see a GP out of hours and/or attend an ED. Where Healthdirect recommends attending an ED, callers are transferred to a Tasmanian-based nurse (funded by the Tasmanian Department of Health) for further triage and all other callers are transferred electronically to a Tasmanian GP. GP Assist provides information on available after-hours options in the caller's area. If the triage GP feels local care by the patient's GP is required, and their GP subscribes to GP Assist, the triage GP can then contact the patient's GP directly and hand over care.	Brighton (60101), Hobart - North East (60102), Hobart - North West (60103), Hobart - South and West (60104), Hobart Inner (60105), Sorell - Dodges Ferry (60106), Launceston (60201), Meander Valley - West Tamar (60202), North East (60203), Central Highlands (Tas.) (60301), Huon - Bruny Island (60302), South East Coast (60303), Burnie - Ulverstone (60401), Devonport (60402), West Coast (60403)
CS7	A geographically based case study focused on the Tablelands and Bowen, which are both located in the **Northern Queensland PHN**. These areas have limited access to after-hours services, ongoing difficulties with GP recruitment, and high demand for in-hours GP services.	Tablelands (East) - Kuranda (30605), Bowen Basin - North (31201)
CS8	A geographically based case study focused on Alice Springs township, which is part of the **Northern Territory PHN**. Alice Springs is the second-largest town in the Northern Territory but is classified as a remote area that has a limited number of GP practices that provide after-hours services.	Alice Springs (70201) *NB Alice Springs SA3 is a very large region covering a large expanse of Central Australia. The case study, however, is limited to the township of Alice Springs.*

Notes: 1. Statistical Area Level 3 (SA3) is one of seven hierarchical levels within the Australian Statistical Geography Standard. The standard is used to disseminate a broad range of Australian Bureau of Statistics social, demographic and economic statistics. SA3s generally have a population of between 30,000 and 130,000 people.

The size and scale of the case studies varied, ranging from those covering the entire population and geography of the PHN to a focus within a single SA3 location or a particular commissioned activity.

Table 4 presents key population, social and demographic data for each case study. Key features of the case studies based on population are as follows:

- **Population size.** Case studies CS1 (Eastern Melbourne) and CS4 (Adelaide) covered the largest populations, both above 1 million people. In contrast, CS8 (Northern Territory), CS7 (Northern Queensland) and CS2 (Brisbane South) had the lowest population reach, due to the narrower geographic definition of the case study scope.
- **Aboriginal or Torres Strait Islander peoples.** Case study CS8 (Northern Territory) had the largest proportion of Aboriginal or Torres Strait Islander people (36.2% of the population). CS7 (Northern Queensland) had the next largest, with 7.5%. The lowest representation was reported in CS1 (Eastern Melbourne) with 0.4%.
- **Older people.** Case study CS5 (HNECC) had the largest proportion of people aged 65 years or older (18.8% of the population), with most case study sites reporting more than 13% of the population as aged 65 years or older. The exceptions were CS2 (Brisbane South, 8.8%) and CS8 (Northern Territory, 6.4%)
- **Children.** Case study CS2 (Brisbane South) had the largest proportion of people aged 14 years or younger (24.0% of the population), with the remaining case study sites reporting in the range 17.8% to 21.7%.
- **English proficiency**. Case study CS1 (Eastern Melbourne) had the largest proportion of people with low English proficiency (17.9% of the population). CS3 (Perth South) and CS4 (Adelaide) reported figures above 10%.
- **Social deprivation.** CS8 (Northern Territory) is the most socially disadvantaged of the case study areas. The metropolitan case study areas (Eastern Melbourne, Brisbane South, Perth South and Adelaide) are the least socially disadvantaged.

Table 4 – Social and demographic features of case study localities, 2016

Social and demographic characteristics	Australia	Major urban				Regional		Remote	
		CS1 Eastern Melbourne	CS2 Brisbane South	CS3 Perth South	CS4 Adelaide	CS5 Hunter New England & Central Coast	CS6 Tasmania	CS7 Northern Queensland	CS8 Northern Territory
Estimated resident population of PHN	23,401,892	1,428,542	1,021,494	928,842	1,183,181	1,211,081	506,074	668,147	224,941
Estimated resident population of in-scope locations based on SA3s	NA	NA	45,363	NA	NA	674,661	NA	73,918	35,949[1]
Median age	38	37.6	37.0	35.8	39.6	40.8	41.3	40.2	32.0
% aged 65 years or over	15.8%	15.6%	8.8%	13.8%	17.0%	18.8%	18.6%	16.7%	6.4%
% aged 14 years or younger	18.7%	18.1%	24.0%	19.3%	17.3%	18.5%	17.8%	20.5%	21.7%
% male	49.3%	48.8%	50.1%	49.7%	48.9%	49.2%	48.9%	51.1%	49.8%
% Aboriginal or Torres Strait Islander	2.8%	0.4%	3.0%	1.8%	1.4%	5.1%	4.2%	7.5%	36.2%
% with low English proficiency	3.5%	17.9%	2.9%	14.5%	12.4%	3.0%	3.8%	3.6%	7.7%
% need assistance with core activities	5.1%	4.7%	4.3%	4.1%	6.0%	6.5%	6.1%	4.6%	3.6%
Index of relative social disadvantage	NA	1,049	1,008	1,012	980	962	950	941	919
% in major cites	71.6%	96.4%	63.6%	98.8%	99.3%	68.0%	0.0%	0.0%	0.0%
% inner or outer regional	26.4%	3.6%	36.4%	1.1%	0.7%	32.0%	97.6%	85.3%	0.0%

Social and demographic characteristics	Australia	Major urban				Regional		Remote	
		CS1 Eastern Melbourne	CS2 Brisbane South	CS3 Perth South	CS4 Adelaide	CS5 Hunter New England & Central Coast	CS6 Tasmania	CS7 Northern Queensland	CS8 Northern Territory
% remote or very remote	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.4%	14.7%	100.0%

Note: 1. Reported figures, with the exception of estimated resident population, are population-weighted averages of the in-scope SA3 locations (see Table 3). Figures presented cover the whole SA3, which is much larger than the case study site of Alice Springs township.

Source: Australian Bureau of Statistics (2016a).

Table 5 presents data for after-hours and related services for each case study locality. Note the data for GP attendances and ED presentations are not age standardised, which makes direct comparisons more difficult.

Table 5 – After-hours and related services

Service measure	Case study by location[1]							
	Major urban				Regional		Remote	
	C1: EM	CS2: BS	CS3: PS	CS4: A	CS5: HNECC	CS6: T	CS7: NQ	CS8: NT
GP attendances (crude rate, per 1,000)[5]								
2015–16	5,916	7,181	5,305	6,243	6,231	5,562	4,652	3,090
2018–19[2]	6,191	6,739	6,192	6,504	6,394	5,859	4,661	3,523
After-hours GP attendances (crude rate, per 1,000)[5]								
2015–16	623	590	384	646	301	184	173	100
2018–19[2]	669	551	469	608	265	187	111	114
Does a medical deputising service operate in the locality (Yes/No)								
	Yes[3]	Yes[3]	Yes[3]	Yes[3]	Yes[3]	Yes[3]	Yes[3]	No
Low-urgency ED presentations (crude rate, per 1,000)[6]								
2015–16	82	60	128	91	200	112	19	NP[4]
2018–19[2]	76	56	121	86	202	118	18	NP[4]
After-hours low-urgency ED presentations (crude rate, per 1,000)[6]								
2015–16	41	27	63	45	97	52	8	NP[4]
2018–19[2]	38	25	58	42	95	53	8	NP[4]
Potentially preventable hospitalisations (age/sex standardised rate, per 1,000)[7]								
2015–16	23	30	25	27	23	23	37	91
2017–18[2]	25	31	25	27	26	26	37	101

Notes: 1. CS1: Eastern Melbourne PHN; CS2: Brisbane South PHN – Jimboomba; CS3: Perth South PHN – 50 Lives 50 Homes After Hours service; CS4: Adelaide PHN – LETTS; CS5: Hunter New England Central Coast PHN – GP Access Program; CS6: Primary Health Tasmania – GP Assist Service; CS7: Northern Queensland PHN- Tablelands and Bowen; CS8: Northern Territory PHN – Alice Springs 2. Most recent published data 3. MDSs only operate in some but not all areas of the PHN 4. NP = Not published

Sources: [5] Australian Institute of Health and Welfare (2020a); [6] Australian Institute of Health and Welfare (2020b); [7] Australian Institute of Health and Welfare (2019)

Key points to note from these data are:

- **GP attendances (crude, per 1,000).** CS2 (Brisbane South) reported the highest rate of attendances (6.7 per person in 2018–19) while CS4 (Adelaide) had a similar rate. CS8 (Northern Territory) reported the lowest rate (3.5 per person). Attendances increased in all areas between 2015–16 and 2018–19, except for the Brisbane South case study.
- **After-hours GP attendances (crude, per 1,000).** CS1 (Eastern Melbourne) reported the highest usage of after-hours GP attendances (0.67 attendances per person in 2018–19). CS7 (Northern Queensland) and CS8 (Northern Territory) reported the lowest rates (0.11 per person), significantly lower than other case study areas. Half of the case study areas experienced increases in after-hours GP attendances between 2015–16 and 2018–19 while the other half declined. In the Northern Queensland case study (CS7) the reduction was 35%.
- **After-hours low-urgency ED presentations (crude, per 1,000).** There are very significant differences in this measure across the case study areas. The rates ranged from 95 in 2018–

19 in CS5 (HNECC) to 8 in CS7 (Northern Queensland). Some of this variation will reflect differences in reporting of ED presentations at small hospitals. Most of the case study areas reported modest reductions in after-hours low-urgency ED presentations from 2015–16 to 2018–19. Data for the Northern Territory PHN case study area is not published.

- **Potentially preventable hospitalisations (PPHs) (age/sex standardised per 1,000).** CS8 (Northern Territory) reported the highest rate of PPHs (101 per 1,000), up 11% from 2015–16. The lowest rates were seen in Eastern Melbourne, Perth South and Tasmania. While PPHs have been relatively stable across case study sites since 2015–16, all sites experienced slight increases or no change in PPH rates from 2015–16 to 2018–19.

Error! Reference source not found. presents after-hours GP attendances and ED presentations for all PHNs. Note that this chart shows the PHN values for the whole PHN, not the specific case study locations. The same chart is shown within the case study reports, but with the specific case study locality highlighted. In the case of Eastern Melbourne, Perth South, Adelaide and Tasmania, the PHN values will be the same as for the case study. The chart plots the rate for the two measures of after-hours utilisation with the black lines indicating the national averages and the blue line the linear relationship between the two measures based on all PHN values. The size of the grey PHN circle indicates the population size.

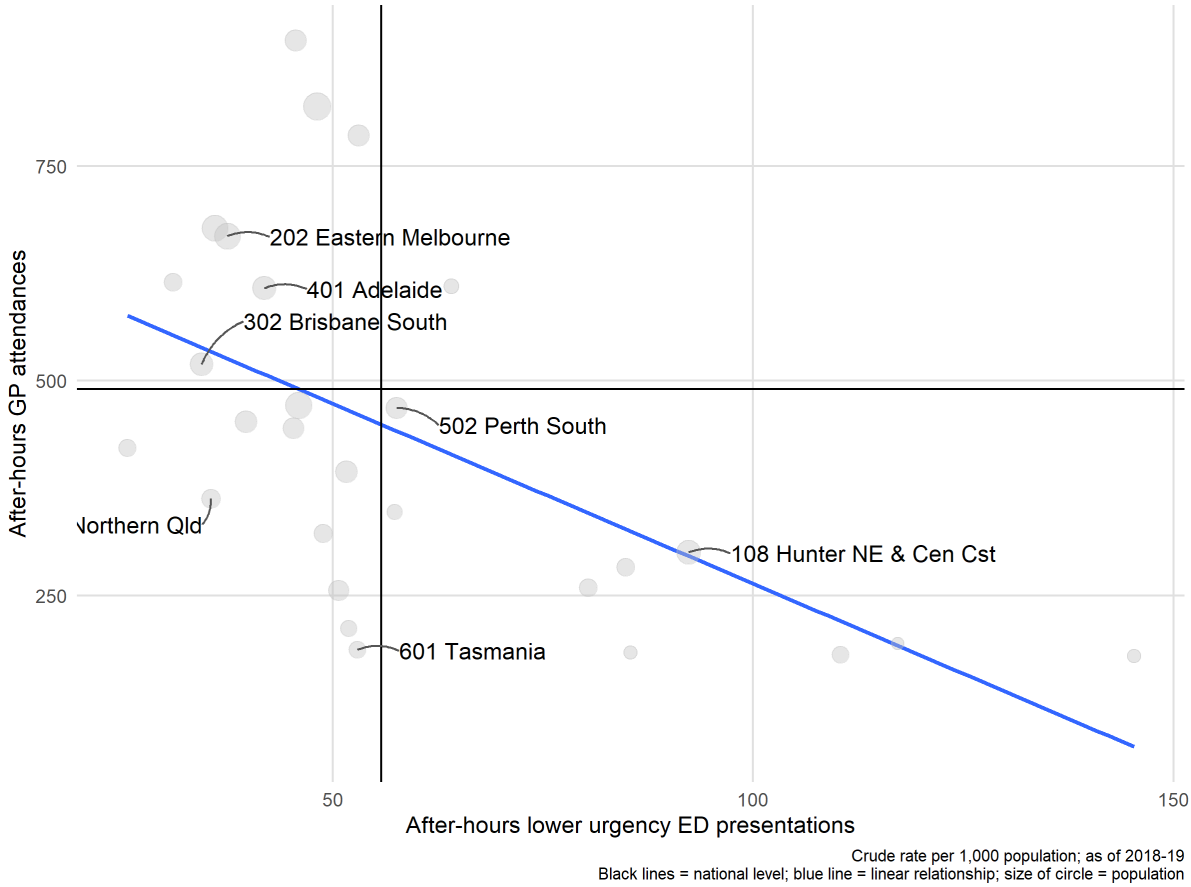

Figure 1 – GP after-hours attendances vs after-hours low-urgency ED attendances, 2018–19

Sources: ED: Australian Institute of Health and Welfare (2020b); GP AH: Australian Institute of Health and Welfare (2020a)

There is significant variation across the PHNs on both measures but there appears to be a relationship that suggests PHNs with higher rates of after-hours GP utilisation have lower rates of ED presentations. Table 6 summarises the number and nature of the activities being undertaken under the After Hours Program in each of the case study areas. This information is based on the Activity Work Plans submitted to the Department of Health.

Table 6 – Commissioned services reported in HPA-commissioned provider survey, 2019–20

Characteristics of commissioned services	Case study by location							
	Major urban				Regional		Remote	
	CS1: Eastern Mel-bourne	CS2: Brisbane South	CS3: Perth South	CS4: Adelaide	CS5: Hunter New England & Central Coast	CS6: Primary Health Tasmania	CS7: Northern Queensland	CS8: Northern Territory
Commissioned activities covered by case study (n)	9	1	1	3	2	3	1	2
PHN AH activities but not in scope of case study	0	4	4	4	3	4	3	4
Types of activities within locality[1]								
Direct patient care	7	4	3	5	4	2	2	2
System and provider capacity building	1	0	1	0	0	1	1	4
Consumer health literacy campaigns	1	1	1	1	0	1	0	0
PHN needs assessments, planning and evaluations	2	0	0	1	1	3	1	0

Notes: 1. Eastern Melbourne PHN commissioned some services that bundled different activities together. For this reason, the number of activities exceeds the number of services

Sources: Adelaide Primary Health Network (2019); Brisbane South Primary Health Network (2019a); Northern Queensland Primary Health Network (2019a); Eastern Melbourne Primary Health Network (2019b); Tasmania Primary Health Network (2019); Perth South Primary Health Network (2019); Hunter New England and Central Coast PHN (2018b); Northern Queensland Primary Health Network (2019a); Northern Territory Primary Health Network (2020)

Table 7 provides information from the survey of commissioned providers within each case study PHN. It lists the services commissioned and the reported numbers of service users or contacts.

Table 7 – After-hours commissioned services within case study areas and numbers of users/contacts

Services commissioned by PHNs	Estimated number of patients/users (latest annual figure unless noted otherwise)[1]
CS1: Eastern Melbourne	**Innovative After Hours Solutions** • My Emergency Dr: 5,096 consults **ED Diversion Project** • 52 ED diversions (May–June 2020) **After Hours Clinic – Outer East and Northern Area** • Ico Health: 38,655 patients attending the clinic • Eastern Health: 4,812 presentations

Services commissioned by PHNs	Estimated number of patients/users (latest annual figure unless noted otherwise)[1]
	After Hours Banksia Palliative Care • 14 doctor support to nursing staff (Feb–May 2020) **RACF Capacity Building** • 202 RACF consults **After Hours Aboriginal Mental Health Liaison Officer** • 414 alcohol and other drugs referrals **After Hours Mental Health Nurse and Liaison Service** • 40 client contacts (Dec 19–July 20) **Family Intervention Support Trial** • 33 family referrals per quarter
CS2: Brisbane South PHN	**After Hours Response** •13SICK: 353 patients seen **After Hours Homeless to Home Nursing Service** •Micah Projects: Average of 300 people per quarter **After Hours Street Doctor Services** • Street Doctor: 330 people
CS3: Perth South PHN	**After Hours Support Service** •50 Lives 50 Homes After Hours: 124 people supported **After-hours primary health care** •Arche Health Limited: 5705 individuals **After Hours Program for South Metro Community Alcohol and Drug Service** •Palmerston Association: 875 counselling sessions, 189 clients treated and 129 new clients (July–Dec 2019)
CS4: Adelaide PHN	**Lived Experience Telephone Support Service** • 5031 client interactions **After Hours Walk-in Clinics** •183 client contacts (July–Dec 2019) **After Hours Extended Mental Health Clinical Services** • 600 service contacts (July–Dec 2019) **Extended Primary Care for RACF – Camellia Project** • 343 recorded clinical interventions **Northern and Southern Paediatric Partnership Program** • 284 project enrolees and 272 assessments completed
CS5: Hunter New England Central Coast PHN	**GP Access – Hunter** • Hunter Primary Care: 74,069 calls and 56,110 patient attendances **GP After Hours Program – Central Coast** • Central Coast Primary Care: 15,634 patient attendances **Aged Care Emergency Program (ACE)** • 3,617 calls **Small Town After Hours Program** • HealthWISE: 8 small towns provided with GP coverage, 1,128 patient consults

Services commissioned by PHNs	Estimated number of patients/users (latest annual figure unless noted otherwise)[1]
CS6: Primary Health Tasmania	**GP Assist – After Hours Telephone-based Advice and Support** • GP Assist: projected 16,000 calls **Moreton Group Medical Services Mobile Health Clinic** • 667 patients seen
CS7: Northern Queensland PHN	**After-hours services** • House Call Doctor: 1,827 consults (Nov 2019–June 2020)
CS8: Northern Territory PHN	• Dr in the House: 215 consults (2 months) • Telstra Health: 362 consultations **After Hours in Regional Hubs** • 2,592 service user attendances **After-hours hospital into primary health care pathways** • 2,330 service user attendances

Note: 1. Based on HPA provider survey

3 Eastern Melbourne PHN

Case study scope and focus

Due to the integrated approach that the Eastern Melbourne PHN has taken to the Program, the case study focused on **the entire PHN region.**

What were the key observations from this case study?

What we learnt:

- Stakeholders noted a **growth in demand** for after-hours services was associated with **population growth** in certain areas.
- In some instances, there appeared to be **limited trust in after-hours care options** beyond the ED.
- The 12-month program funding cycles and general uncertainty about the future of the program impacted the PHN's ability to:
    - plan effectively
    - co-commission and co-design after-hours activities, and
    - commission larger-scale projects that may have had a broader impact on the PHN population.
- It is difficult for PHNs to attribute the extent to which after-hours services reduce ED demand.
- **Recruiting GPs and other health professionals to work after hours was an ongoing challenge** in the region and had become more difficult with changes to both the eligibility for MBS after-hours items and the recruitment of overseas doctors.
- **Collaboration, service integration and information sharing were continuing challenges** for stakeholders, and there are opportunities to improve these across the health system.

Locality overview

The Eastern Melbourne PHN spans 12 local government areas (LGAs) and has a population of 1.5 million people, which equates to 24 per cent of the population of Victoria. The region continues to experience high population growth, with the number of residents projected to increase to 1.85 million in 2031 (Eastern Melbourne Primary Health Network, 2018a). Much of the PHN region is classified as urban and a large proportion of the Eastern Melbourne PHN region falls under the Modified Monash Model category 1 or 2 level of remoteness. Despite the PHN region's predominantly urban geography, the outer northern and eastern areas of the catchment fall under the MMM category 5 (inner regional Australia) (Department of Health, 2018a).

The PHN has an average proportion of the population aged 65 and older (around 15%) but this is expected to increase to 20% by 2031 (Eastern Melbourne Primary Health Network, 2018b). Although Aboriginal & Torres Strait Islander people make up a small proportion of the population (0.4%), this group experiences poorer health outcomes than other Eastern Melbourne PHN residents. The Eastern Melbourne PHN region is very culturally diverse with 32% of residents born overseas and has a high CALD and refugee population.

Though 87% of residents reported excellent or very good health, the catchment grapples with high rates of chronic disease – 80% of adults have one or more chronic conditions and 80% of residents aged 65 and older have three or more chronic conditions. In addition, 10%

of residents in the PHN region struggle with a disability and require daily support. Providing mental health and alcohol and other drugs support has also been a core focus for the PHN as one in five Victorian residents reported dealing with a mental health issue annually and seven out of 10,000 deaths can be attributed to drug overdose. Overall, the region had a higher life expectancy (males: 82.9% vs 80.4%; females: 86% vs 84.6%) and lower rates of physical inactivity (52% vs 56%) and excessive alcohol consumption (15% vs 17%), but higher rates of smoking (18% vs 14.7%), and overweight and obese residents(64.7% vs 62.8%) than the national average (Eastern Melbourne Primary Health Network, 2018b, 2018c). Figure 2 shows the geographical area covered by the Eastern Melbourne PHN.

Figure 2 – Map of the Eastern Melbourne PHN

Source: Department of Health (2015)

Compared with the 31 PHNs in Australia (Australian Bureau of Statistics, 2016a), Eastern Melbourne PHN was ranked:

- **4th** in terms of the total population covered
- **6th** in terms of the proportion of the population with low English proficiency
- **30th** in terms of the proportion of Aboriginal and Torres Strait Islander peoples supported.

Figure 3 presents data indicating access to primary health care in the after-hours period was relatively high compared with other PHNs. In particular:

- GP after-hours MBS services per 1000 residents was **669**, higher than the national average of **490**, ranking it **5th** highest of all 31 PHNs on this measure.
- After-hours low-urgency ED attendances per 1000 residents were **41**, lower than the national average of **56**, and the **6th** lowest of all 31 PHNs on this measure

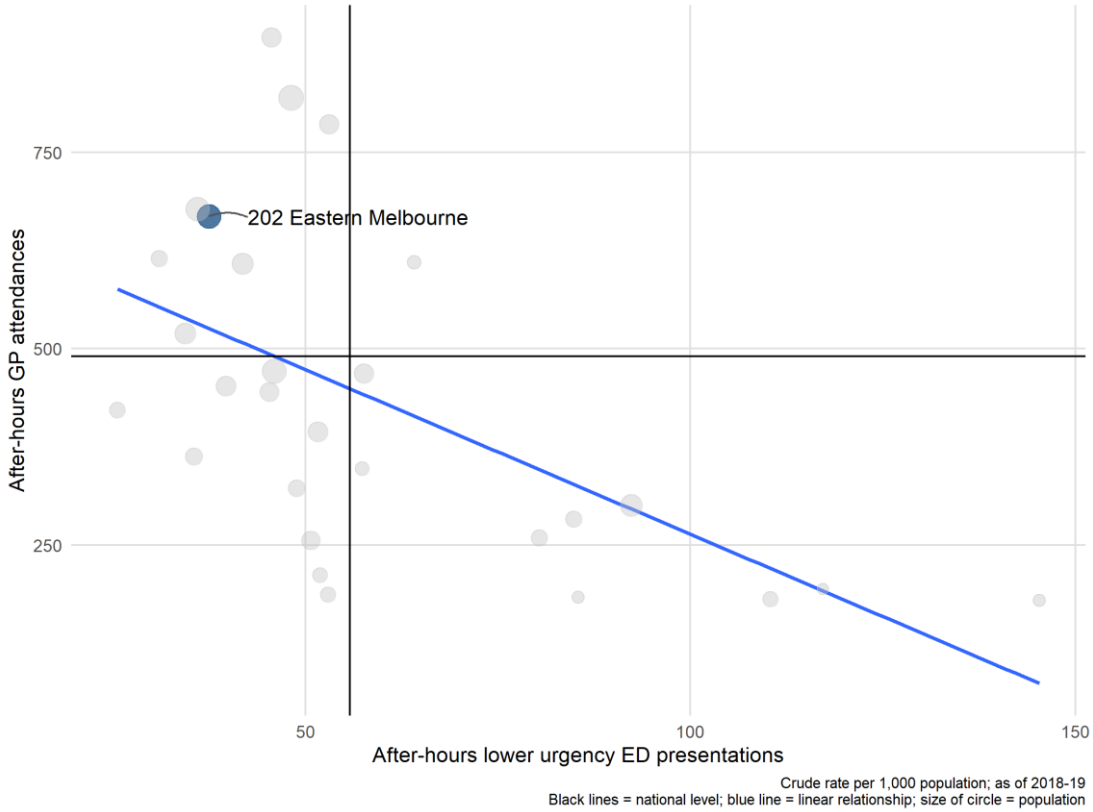

Figure 3 – GP after-hours services vs after-hours low-urgency ED attendances, 2018–19

Sources: ED – Australian Institute of Health and Welfare (2020b); GP AH – Australian Institute of Health and Welfare (2020a).

Health services within the case study service setting/locality

Table 8 provides a high-level summary of the services that operate within the PHN region.

Table 8 – Summary of relevant health services within Eastern Melbourne PHN

Type	Number and service parameters
GP practices	384
Public & private hospital centres	41
Pharmacies	321
After-hours supercare pharmacies	3 – *As part of the Victorian Department of Health and Human Services' Supercare Pharmacy initiative, these pharmacies are open 24/7 and operate a nurse-led clinic from 6-10 pm seven days a week.*
Community health centres	23
Mental health providers	437
Alcohol & other drug services	28
Nurse and GP telephone helplines	NURSE-ON-CALL and My Emergency Doctor

Source: Eastern Melbourne Primary Health Network (2018a); Eastern Melbourne Primary Health Network (2020)

Eastern Melbourne PHN approach

In 2015, the Eastern Melbourne PHN was formed from the amalgamation of three Medicare Locals that were operating in the region. Since the establishment of the PHN, the organisation has sought to shift away from funding smaller-scale, grant-based projects and

taken a more innovative approach to commissioning services on a larger scale. The Eastern Melbourne PHN's strategies for service commissioning are displayed in Figure 4.

Figure 4 – Eastern Melbourne PHN commissioning strategies

Source: Eastern Melbourne Primary Health Network (2019a)

Overarching After Hours Program aims

Eastern Melbourne PHN set the key objective of their After Hours Program to improve the overall effectiveness and access to after-hours care through productive planning, collaboration and support of after-hours services.

Along with these core program aims, the PHN also identified the following supplementary objectives:

- Focus on addressing existing service gaps and potential inequity of access to after-hours care by considering vulnerable groups and rural and remote populations who may not have benefitted from previous after-hours service arrangements.
- Improve patient outcomes by working collaboratively with health providers and services.
- Reduce after-hours service fragmentation, enhance efficiency and effectiveness of the health system, and establish services that foster effective communication and continuity of care between after-hours providers and patients' regular GPs.
- Engage and work with key stakeholders, to plan, coordinate, and support population-based after-hours primary care.
- Support local solutions and enable increased emphasis and support for specific population groups.
- Raise consumer awareness of after-hours primary health care that is available in the catchment and improve patient health literacy of after-hours service options.
- Help fund the two after-hours clinics in Box Hill and Healesville (Eastern Melbourne Primary Health Network, 2020).

Needs assessment process

To identify further specific after-hours program areas and priorities of focus beyond those sourced from the needs assessment, the PHN produced two separate after-hours needs assessment reports in 2017 and 2019. These assessments drew from a large range of qualitative and quantitative data sources including:

- stakeholder interviews (i.e. LHNs, Ambulance Victoria)
- interviews with the Eastern Melbourne PHN community advisory committee and clinical council
- interviews with community providers (i.e. GPs, RACFs)
- interviews with Eastern Melbourne PHN-commissioned providers
- ED presentation data
- Australian Institute of Health and Welfare data
- the Victoria Emergency Medicine Data set
- general practice data
- Practice Incentive Program (PIP) data
- MBS claims related to after-hours items
- data acquired from MDS and telehealth services.

The PHN commissioned an external consultant to undertake an after-hours needs assessment in 2019 and reflected that helping to produce this report was an easier and smoother process due to the increased experience of internal staff, a better understanding of the relevant data sources required to inform the report, and the ability to draw on findings from the needs assessment that was completed in 2017 (Eastern Melbourne Primary Health Network, 2018b).

In line with the After Hours Program's core objectives and the Eastern Melbourne PHN's high-level strategic aims highlighted in the 2018 Needs Assessment Report, the 2019 After Hours Needs Assessment Report identified the following population groups and communities as priorities of focus for the PHN After Hours Program:

- Young people under the age of 15. This cohort represents a high percentage of the Eastern Melbourne PHN population that present to the ED with non-urgent or non-life-threatening conditions.
- Individuals that reside in Banyule and Manningham East. Residents in these areas attend the GP less frequently than other Eastern Melbourne PHN regions.
- Individuals that reside in Banyule, Yarra Ranges and Knox. Low acuity and non-urgent ED presentations are the highest in these areas.
- Additional population groups of focus include:
- individuals experiencing mental health issues
- individuals experiencing issues with drugs or alcohol
- individuals who live in rural and regional areas
- individuals who are experiencing homelessness
- Aboriginal and Torres Strait Islander people.

GPs in the Eastern Melbourne PHN treated 94% of non-urgent primary care after-hours needs, but the PHN estimated that non-urgent cases still represented a third of all ED presentations in the region (Eastern Melbourne Primary Health Network, 2019b). Certain populations and communities were more frequently seeking treatment at the ED for non-urgent conditions, and they may have had less access to or awareness of after-hours primary care options within their regions (Eastern Melbourne Primary Health Network, 2019b).

Along with these communities and populations of focus, the PHN also identified the following quality aims:

- increase the uptake of shared health records
- improve patient navigation during the after-hours period

- foster ED diversion activities that reduce non-urgent ED presentations and promote increased usage of after-hours community health services (Eastern Melbourne Primary Health Network, 2019b).

Needs assessment challenges

The Eastern Melbourne PHN and stakeholders discussed several challenges associated with undertaking the after-hours needs assessment:

- Ensuring there is input from a wide range of consumers, organisations and patient cohorts – such as young people, CALD groups, and Aboriginal & Torres Strait Islanders – is a difficult task and the current Activity Work Plan and other funding timelines further hinder this aim.
- Data limitations, such as the timeliness and a lack of availability from certain data sources (e.g. PIP and demographic data) made it more difficult for the PHN to effectively identify gaps in after-hours services and potential areas of need.
- Short-term funding cycles and overall uncertainty of the future of the program have been barriers to adopting some of the needs assessment recommendations and implementing more strategic program changes.

Annual funding and PHN After Hour Program activities

Total annual funding for the After Hours Program for the past two financial years is presented in Table 9 below. Eastern Melbourne PHN funding was about $2.5m and amounted to just over half of the average level of funding across all PHNs.

Table 9 – Summary of Eastern Melbourne PHN After hours funding

Financial year	Total After Hours allocated program funding (PHN)	After Hours funding per 1,000 population (PHN)	All PHN After Hours Program funding per 1,000 population	PHN ranking (After Hours funding per 1,000 population)
2019–20	$2,403,785	$1,683	$3,056	25th
2018–19	$2,434,785	$1,704	$2,867	25th

Source: Department of Health communication.

Following the needs assessment in 2019, Eastern Melbourne PHN conducted a market analysis to identify after-hours services available within the catchment. Following this, the PHN approached the market with a request for tender for after-hours care, where prospective providers could put forward proposals targeting specific areas and/or population groups, or proposals that could service the entire catchment. In previous years, the PHN ran a variety of different programs and small grants but decided to try a new approach in 2019 with a single tender containing various elements.

The PHN classified its nine smaller after-hours activities into four overarching groups representing the key areas the organisation identified through needs assessment. The total funding allocated for each priority area and the subsequent individual activities are reflected in the PHN's 2019–20 Activity Work Plan set out in Table 10.

Table 10 – Eastern Melbourne PHN after-hours activities and planned expenditure[1]

Priority area	Planned expenditure 2019–20[2]	
	$'m	%
1.0 Enhanced and innovative after-hours services that demonstrate integration and collaboration across the after-hours service sector	**$1,344,608**	**60%**

Priority area	Planned expenditure 2019–20[2]	
	$'m	%
1.1 – Innovative after-hours solutions	$712,608	32%
1.2 – After Hours ED Diversion Project	$195,000	9%
1.3 – After Hours Clinic in the Outer East & the Northern Area After Hours Access Project Stage 2	$437,000	19%
2.0 After-hours vulnerable groups	**$235,000**	**10%**
2.1 – After Hours Palliative Care in the North and East	$160,000	7%
2.2 – RACF Redesign Capacity Building	$75,000	3%
3.0 After-hours mental health	**$532,000**	**24%**
3.1 – After-hours Aboriginal mental health liaison officer and After-hours alcohol and other drugs worker	$145,000	6%
3.2 – After Hours Mental Health Nurse and Liaison Service	$250,000	11%
3.3 – The Northern Mental Health: Family Intervention Support Trial	$137,000	6%
4.0 After-hours community awareness	**$137,000**	**6%**
4.1 – Community Awareness campaigns with a focus on exploration of real-time ED monitoring	$137,000	6%
Total	**$2,248,608**	**100%**

Source: 1. Eastern Melbourne Primary Health Network (2019a); Note: 2. Figures presented here may differ from the allocated funding for a variety of reasons e.g. carry forward of funds from the previous financial year or funding retained for administrative costs.

Eastern Melbourne PHN after-hours activities

1.0 Enhanced and innovative after-hours services that demonstrate integration and collaboration across the after-hours service sector

In an effort to reduce non-urgent ED presentations and improve access to after-hours primary care services, the PHN commissioned the '*Enhanced and innovative after-hours services that demonstrate integration and collaboration across the after-hours service sector*' initiative, which included several activities that seek to increase community after-hours primary care options for certain communities and population cohorts, increase access to the outer east and northern areas of the Eastern Melbourne PHN catchment that may be under-served, and divert low-acuity presentations from the ED.

The project allocated funding to the My Emergency Doctor telehealth service, to provide after-hours support to areas with limited access to after-hours services. My Emergency Doctor is a telemedicine service that gives patients access to emergency specialists via phone and video. In addition to the My Emergency Doctor service, the project funded Nexus Primary Health to deliver an after-hours 'medical neighbourhood' in the northern area of the catchment. While residents of Victoria have access to NURSE-ON-CALL, this service provides advice and can divert calls to the ambulance service but not to a GP (unlike Healthdirect which is able to do so in the after-hours period). The PHN expressed concerns about GP and locum shortages in this part of the PHN and wanted to commission a service that would help prevent patients going to ED if they were unable to access a GP service and also provide direct support to residential aged care facilities.

The Eastern Melbourne PHN contracted with four Local Health Networks (LHNs) and several participating practices in the catchment through the After-Hours ED Diversion Project. The ED diversion project aimed to allow local practices to extend normal operating hours and establish stronger partnerships and patient pathways. As a practical example, Austin Health

LHN specifically focused on triaging and diverting local RACF residents away from the ED, so RACF staff could more appropriately manage these residents at their facilities. The project uses certain telehealth services, such as My Emergency Doctor, to help triage and manage these patients. Eastern Health is also focused on a specific cohort. At the time of the case study, the Eastern Health service was in the initial stages of this project and intended to use this funding to provide education to refugees on the Australian health system and to educate the GP workforce on this population and their needs.

The After-Hours Clinic in the Outer East and Northern Area After Hours Project provides funding for GP clinics in the outer east and northern areas of the catchment to extend their operating hours to the after-hours period. The project also funds additional services in certain areas, such as the provision of after-hours psychology services in Healesville. The commissioned providers also reported using the funding for after-hours workforce recruitment and training.

2.0 After-Hours vulnerable groups

The After-Hours Palliative Care in the North and East program targets residents in these regions who require palliative care services and support. The activity is delivered by Banksia Palliative Care and allows them to extend their services to provide GP support to nurses on weekends.

The RACF Redesign Capacity Building program focuses on providing workforce training and education to RACF staff, LHNs, GPs, telehealth and residential in-reach services to better manage and treat RACF residents in their facilities and limit avoidable ED transfers and hospitalisations.

3.0 After-hours mental health

The after-hours Aboriginal mental health liaison officer and alcohol and other drugs worker program funds extended hours of these services in ED. This service helps Aboriginal & Torres Strait Islander people better navigate the health system, reduces further ED presentations, creates a more culturally supportive environment, and fosters patient assessments, linkages and referrals to community alcohol and other drugs and mental health services.

The After-Hours Mental Health Nurse and Liaison Program funds a mental health nurse in the Box Hill Community to provide after-hours mental health support to individuals who present to the Box Hill ED with low-acuity mental health issues.

The Northern Mental Health Family Intervention Support Trial initiative offers mental health intervention services to families in the northern area of the PHN catchment that may benefit from these services.

4.0 After-hours community awareness

The Community Awareness Campaigns initiative was designed to raise consumer awareness of after-hours options within the community, enhance the overall health literacy of residents and share information about current ED wait times during the after-hours period. This initiative is carried out in collaboration with local general practices, LHNs and the wider community. It uses demographic and service utilisation data to help identify potential areas of focus (Eastern Melbourne Primary Health Network, 2019a).

What impact has the program had?

Though not all service providers have shared their activity data, the PHN and several commissioned providers supplied specific activity measures and patient volumes with respect to the most recent financial year. This information is summarised in Table 11.

Table 11 – Commissioned after-hours service volume measures

Commissioned service name	Measure	Volume*
Innovative after-hours solutions • My Emergency Doctor • Nexus Primary Health	**My Emergency Doctor:** Number of telehealth consultations	5,096
After Hours ED Diversion Project • Eastern Health LHN • Monash Health LHN – still in planning stages, due to commence June 2020 • Austin LHN – Project recently commenced (no data yet) • Northern LHN – Project planning stage • Participating clinics: Burwood Healthcare, Carrington, Box Hill Superclinic	**Eastern Health LHN:** Number of ED Diversions	52 (Project commenced May 2020)
After Hours Clinic in the Outer East and the Northern Area After Hours Access Project • Ico Health • Eastern Health	**Ico Health – Lakes Boulevard Medical**: Number of patients attending the practice during after hours	38,655
	Number of patients diverted from ED	258 (Aug–Nov 2019)
	Eastern Health – Healesville After Hours GP Clinic: Number of presentations	4812
	Number of ED diversions	304
	Number of Aboriginal & Torres Strait Islander presentations	72
After Hours Palliative Care in the North and East • Banksia Palliative Care	Number of times Banksia doctors have been contacted by Banksia nursing staff	14 (Feb–May 2020)
RACF Redesign Capacity Building • Austin Health • My Emergency Doctor	Number of RACF consultations via My Emergency Doctor	202 consults
After Hours Aboriginal Mental Health Liaison Officer[1] • Melbourne Health	Number of alcohol and other drugs referrals	414
After Hours Mental Health Nurse and Liaison Service • Carrington Health	Number of client contacts	40 (Dec 2019–July 2020)
The Northern Mental Health: Family Intervention Support Trial • Melbourne Health	Number of family referrals	33 per quarter
	Average contacts per family	3.8 last quarter
	Completion of pre- and post-service questionnaires	70 last quarter

Notes: 1. Funding for the After Hours Aboriginal Mental Health service, which is listed in the Eastern Melbourne PHN 2019–2020 Activity Work Plan, was committed in June 2019 but was due to commence in September 2020; Unless specified otherwise, volume represents figures from the most recent financial year.

The PHN and stakeholders observed the following in relation to data and measuring outcomes:

- The commissioned service providers submitted a wide variety of data to the PHN through monthly, six-monthly and yearly reports. This included both qualitative and quantitative data such as patient volume, reasons for attendance, feedback and reported outcomes measures.
- Overall, Eastern Melbourne PHN considered its reporting comprehensive and that its outcome measures identified whether a service was meeting its objectives.
- Though some services, such as My Emergency Doctor and the Healesville After hours clinic, collected information on the services' potential effect on ED demand, it is difficult to specifically attribute the extent to which after-hours services reduce ED demand (i.e. patient accessed an after-hours service instead of attending the ED) and the overall impact on the EDs.
- Some providers expressed the need for improved data linkages between other Eastern Melbourne PHN program areas, such as mental health and chronic disease, and increased data sharing among stakeholders and commissioned service providers. For example, one after-hours GP practice mentioned the value in data sharing agreements with local hospitals that show the common types of low-acuity ED presentations, allowing practices to better understand local health needs and establish stronger working relationships with these hospitals.
- Consultations with commissioned providers identified issues and gaps in data collection for vulnerable groups, such as CALD and refugee groups, which have made it harder to effectively identify the real depth and scope of patient need.

General program reflections

The Eastern Melbourne PHN catchment is growing rapidly and demand for after-hours services is high. Several stakeholders and commissioned providers, specifically providers at after-hours GP clinics, discussed the high demand for after-hours primary care services. Though there are certain regions throughout the catchment that have good access to after-hours primary care services, other areas, especially in the north and east of the catchment, have less after-hours coverage and their populations are growing rapidly. One GP after-hours clinic located in the northern area of the PHN catchment stated that, despite discouraging walk-ins, the practice was booked out every night during the after-hours period (excluding the initial COVID-19 lockdown). My Emergency Doctor, which covers the whole PHN catchment, was contracted to complete 420 consults a month and completed 700 in March 2020. Banksia Palliative Care said the number of patients who required palliative care services was double what they anticipated, and they hired additional staff members to meet demand.

An issue raised in stakeholder consultations was the effect of extending the availability of after-hours services and whether this shifted some demand from in hours to after hours as this was more convenient for some patients. Some stakeholders advised strategies to address this such as leaving gaps in bookings to make space for urgent after-hours patients and not accepting walk-ins.

The Eastern Melbourne PHN appeared to have strong relationships with its commissioned providers. After-hours commissioned providers often reflected on the strong relationships and communication they have with the Eastern Melbourne PHN. They reported that they were engaged with the PHN frequently in the form of:

- regular management meetings
- quarterly meetings
- quarterly and/or monthly reporting
- commissioned provider collaborative group meetings
- PHN weekly newsletters.

Many PHN-funded after-hours projects focused on expanding the capacity of existing services. The core focus of the program has been building on existing service capability and

service integration, which is reflected in their after-hours service design and commissioning approach.

Beyond My Emergency Doctor, which is relatively new and commissioned by the PHN in 2018, the Eastern Melbourne PHN has predominantly focused on filling after-hours gaps with existing community services. In many instances, the PHN has used the after-hours funding to increase services' capacity to deliver after-hours services to potentially under-served regions or specific vulnerable cohorts. The core focus of the program has been service integration, which is reflected in their after-hours service design and commissioning approach.

Challenges for providing access to after hours in this locality

The PHN's needs analysis and the evaluation identified the following issues relevant to planning and providing after-hours access.

Recruiting GPs and other health professionals to work during the after-hours period was an ongoing challenge. Stakeholders reported challenges recruiting GPs and other health professionals to work during the after-hours period. Due to an increased emphasis on work/life balance, stakeholders across Australia stated that it has become more difficult to get GPs and health professionals to work after hours. The PHN has attempted to address these workforce challenges by limiting after-hours service hours to certain days in some areas, such as Healesville, and by funding My Emergency Doctor, which the PHN reported has provided continuity of workforce by using ED doctors to improve access to after-hours services.

In addition to challenges associated with general after-hours workforce recruitment, several developments and existing restrictions in the region make it more difficult for providers to recruit GPs and other health professionals to work during after-hours periods. Commissioned providers reflected that the changes to MBS after-hours items and the reduction in visas granted to overseas GPs in metropolitan areas has hindered their ability to recruit additional workers and meet the existing demand. In addition, regional changes to the District Workforce Shortage classification have made it harder for clinics in certain areas, such as Healesville, to recruit GPs.

In some instances, there was limited trust in and awareness of after-hours care options beyond the ED. Consumer trust in after-hours service providers is an ongoing issue that may affect consumer choices and their decisions to access the ED instead of alternative community after-hours options. If their regular GP clinic is closed, consumers may have more faith in the ED than other after-hours services and know that they will be able to access additional services at the ED that may not be available at an after-hours clinic, such as pathology and radiology services. The out-of-pocket cost to attend or access other after-hours services is another disincentive.

Some stakeholders remarked that consumers may have more trust and confidence in certain after-hours services that offer specialist advice, such as My Emergency Doctor, because they are able to engage with and speak directly to emergency care physicians regardless of their location within the PHN area. There was no opportunity to test this directly with consumers as part of the case study.

Collaboration and service integration was a continuing challenge for some service providers. Commissioned service providers said there is the potential for additional collaboration and communication between community stakeholders. For example, commissioned providers that operate after-hours clinics stated they would like increased engagement and stronger relationships with local hospitals in the Eastern Melbourne PHN catchment. Other commissioned providers mentioned they would like stronger partnerships and increased collaboration with RACF management, other commissioned providers, and GP clinics.

The 12-month program funding cycles and general uncertainty around the future of the program has impacted the PHN's ability to plan effectively, co-commission and co-design after-hours activities, and commission larger-scale projects that may have had a broader impact on the PHN population. The PHN reflected on the difficulty of achieving certain needs assessment objectives, evaluating after-hours services, co-designing and co-commissioning after-hours activities and making more strategic program changes and investments due to the short-term program funding cycles and general uncertainty around the future of the program. Due to these existing arrangements, the PHN has been more conservative in co-designing and co-commissioning services, but they would like to take a more collaborative approach in the future. Specifically, they expressed interest in co-commissioning ED diversion projects with LHNs within the PHN catchment.

Though stakeholders and PHN staff recognised the value in having a separate bucket of funding for after-hours services, they considered that there are existing issues around the reporting burden given the level of funding that is allocated to the PHN After Hours Program. They suggested that there should be less focus on minute program details and more emphasis on broad program impacts and outcomes.

It was difficult to design and commission more innovative models of care. It has historically been difficult for Eastern Melbourne PHN to design and commission innovative models of care, such as telehealth services. The establishment of the telehealth MBS item numbers due to COVID-19 has been helpful in increasing access to telehealth and making these services more viable for providers. There is potential to make further use of these MBS items.

A lot of early work has been carried out to help design and commission innovative after-hours models of care, but this information has not been consolidated or shared between PHNs and some of the business knowledge has been lost. Therefore, there is potential for increased collaboration and work on designing and commissioning innovative after-hours services that serve the wider community.

Improving the program

Opportunities to improve the program were identified as follows:

- This is a need to **develop more collaborative and strategic partnerships** between stakeholders, the PHNs, the state health system and commissioned providers. Though Eastern Melbourne PHN is working to further integrate services and establish stronger relationships between stakeholders and commissioned providers, of which the After Hours ED Diversion project is an example, there are further opportunities to foster these relationships. The Victoria Department of Health did have an after-hours working group, but this has since been dissolved. In addition, the PHN reflected that there has been a reduction in communication between the PHNs, which hinders collaboration and the sharing of information. It would benefit the PHN to increase engagement at both the state and national level.
- The PHN After Hours Program **funding cycle and agreements need to be longer than one year.** This would assist greatly in planning, co-design and co-commissioning of activities, achieving needs assessment objectives, implementing more strategic program changes, and funding larger, broader-reaching initiatives.
- There is an opportunity to provide **additional consumer health literacy, promote awareness and increase trust** in alternative after-hours care options beyond the ED.

Stakeholders consulted and survey responses

Table 12 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other

PHN	2		
My Emergency Doctor		2	
Lakes Boulevard Medical		2	
Northern Health		1	
Austin Health		1	
Banksia Palliative Care Service		1	
Clinician (PHN Board and Clinical Advisory Council)			1
Consumer (PHN Community Advisory Council)			1
Total	**2**	**7**	**2**

Table 13 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider surveys	7

4 Brisbane South PHN

Case study scope and focus

The Brisbane South PHN case study was both **program-based and geographically based** with a focus on the delivery of a **Medical Deputising Service (MDS) in Jimboomba**. The area (SA3) of Jimboomba has a population of 45,587 persons (Australian Bureau of Statistics, 2016d) and is approximately 50km south of Brisbane.

What were the key observations from this case study?

What we learnt:

- **There can be after-hours service gaps in metropolitan PHNs even where supply of after-hours GP clinics is appropriate for the majority of the population**. Jimboomba, in the Brisbane South PHN, was not well supported in the after-hours period and distance and travel times were a significant barrier to an MDS being established and sustained.
- The MDS was not able to engage in direct consumer advertising in line with the Department of Health guidance. The MDS can promote the service to GP practices and this formed part of the 13SICK's engagement plan. The restrictions in promoting and increasing awareness appeared to limit the growth and usage of the MDS. Services of this nature, particularly in the establishment phases, **need to be supported by strategies to work closely with general practices, service providers and others** so that consumers are able to access care and the after-hours services are well integrated with general practice.

Locality overview

The Brisbane South PHN comprises four local government authorities: Brisbane City, Logan City, Redland City and Scenic Rim Regional, covering urban, rural and remote regions. Its geographic boundary is directly aligned with that of the Metro South Hospital and Health Service.

Figure 5 illustrates the location and key localities with the Brisbane South PHN.

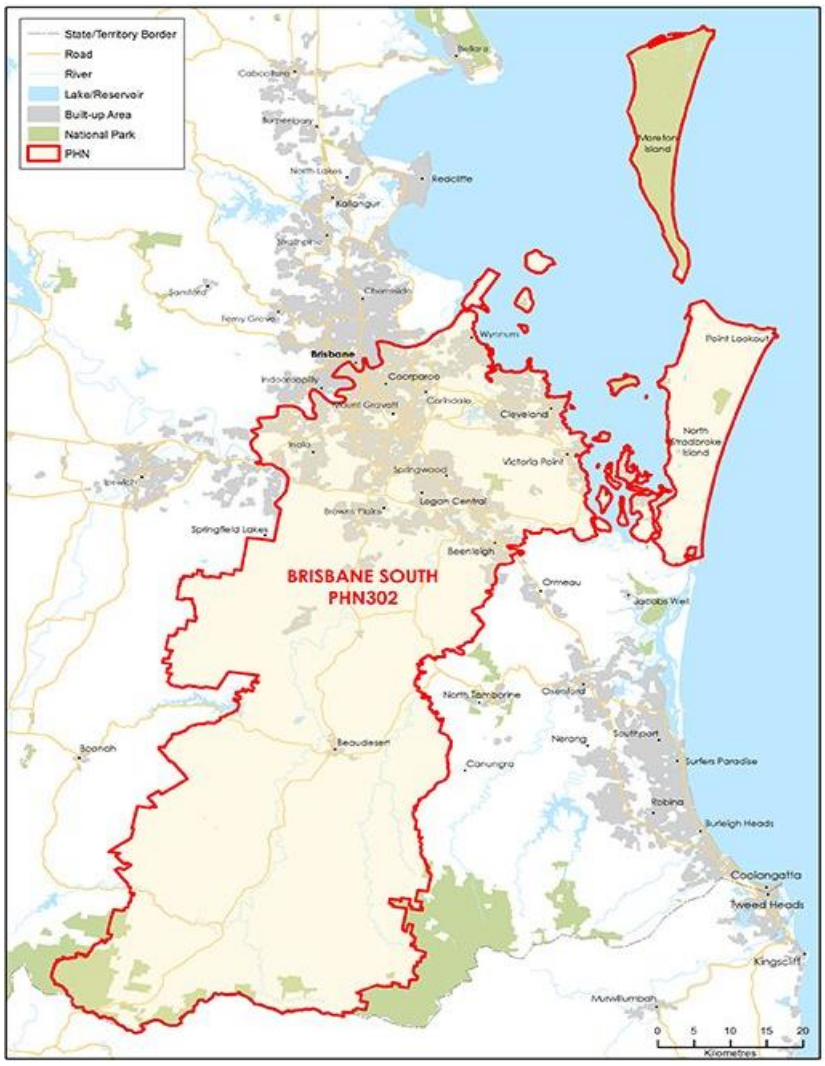

Figure 5 – Map of the Brisbane South PHN

Source: Department of Health (2015)

The Brisbane South PHN has a population of 1,021,494, which is 23% of the state's population (Australian Bureau of Statistics, 2016a). Key health population, profile and service characteristics include (Brisbane South Primary Health Network, 2019b):

- Brisbane South is the area of highest refugee settlement within Queensland.
- 23,122 residents identify as Aboriginal and Torres Strait Islander peoples (2 per cent of the regional population).
- There is a large proportion of vulnerable populations: CALD, refugees, older people and Aboriginal and Torres Strait Islander peoples.
- There are 333 general practices, 1,360 general practitioners and six GP visits on average per annum.
- There are 1,671 nurse and midwife practitioners.
- There are 824 pharmacists.
- There are seven public hospitals: Beaudesert Hospital, Logan Hospital, Princess Alexandra Hospital, Queensland Children's Hospital, QEII Jubilee Hospital, Redland Hospital and Mater Public Hospital.
- There are six private hospitals: Greenslopes Private Hospital, Mater Private, Mater Mothers' Private Brisbane, Mater Mothers' Private Redland, St Vincent's Private Hospital and Sunnybank Private Hospital.
- There are eight community health centres: Beenleigh CHC, Browns Plains CHC, Corinda CHC, Eight Mile Plains CHC, Inala CHC, Logan Central CHC, Marie Rose Centre, Redland

Health Service Centre, Logan Central CMHC, Southern Queensland Centre of Excellence – Inala, Woolloongabba CHC and Wynnum-Manly CHC.
- There are eight ACCHS.

Under the Modified Monash Model, the region covers four categories: Major Cities (MM1, representing 96.1% of the PHN's population), Inner Regional (MM2, 3.4% of the PHN's population); Outer Regional (MM3, 0.3% of the population) and Remote Australia (MM4, 0.2% of the population) (Brisbane South Primary Health Network, 2019b).

In comparison to the 31 PHNs in Australia (Australian Bureau of Statistics, 2016a), the Brisbane South PHN is ranked:

- **7th** in terms of the total population supported
- **9th** in terms of the proportion of the population aged 14 years old or younger.

26th in terms of the proportion of the population aged 65 years or older. Figure 6 presents data demonstrating that access to primary health care in the after-hours period was a little higher than the national average. In particular:

- GP after-hours services per 1000 residents was **519**, higher than the national average of **490** – Brisbane South PHN was ranked **9th** highest of all 31 PHNs on this measure.
- After-hours low-urgency ED attendances per 1000 residents was **34**, less than the national average of **56** – Brisbane South PHN was ranked **3rd** lowest of all 31 PHNs on this measure.
- For the case study area (shown as CS2 in Figure 6) the rates of after-hours GP attendances was slightly higher than for the PHN as a whole and low-urgency ED presentations were lower than for the whole PHN. This may reflect the longer travel times and more limited access for the population based in the case study locality of Jimboomba.

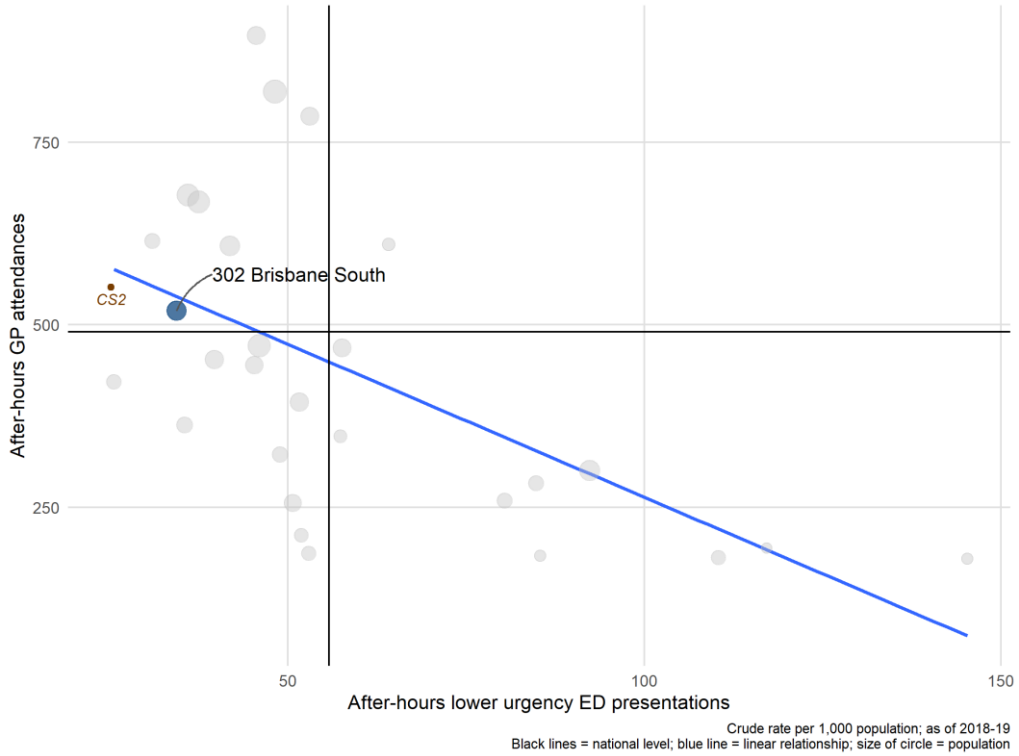

Figure 6 – GP after-hours services vs after-hours low-urgency ED attendances, Brisbane South PHN, 2018–19

Sources: ED – Australian Institute of Health and Welfare (2020b); GP AH – Australian Institute of Health and Welfare (2020a)

Brisbane South PHN's approach

In 2015–16, Brisbane South PHN commissioned The Science of Knowing to undertake the initial local health needs assessment. More recently, the PHN completed a general needs assessment in 2017 (published 2018) informed by comprehensive data analysis, stakeholder engagement, service mapping, research and documentation (Brisbane South Primary Health Network, 2018a).

Brisbane South PHN's Board, Clinical Council, Community Advisory Council, partners and member organisations were regularly consulted and provided feedback throughout the process. The PHN considered the health needs from four different perspectives: people, places, health and system.

The needs assessment also incorporated analysis of after-hours services and utilisation, including usage of 13 HEALTH, Queensland's state-run 24-hour telephone health advice service. 13 HEALTH is staffed by registered nurses who provide telephone assessments and recommendations for a time and place of care. The general needs analysis concluded that most locations in Brisbane South were fairly well served by after-hours primary care service such as GPs and MDSs.

In 2018, Brisbane South PHN commissioned Deloitte to conduct of further review of after-hours GP services. Conducted between July and October 2018, the review had two key findings (Deloitte, 2018):

- From an equity of access perspective, there was demand and need for after-hours primary care services in **Mt Gravatt and Jimboomba** given:
    - Highest representation (SA3 level) of low-acuity after-hours ED presentations
    - Relatively limited access to after-hours providers considering the size of the population
    - High population growth in Jimboomba.
- The highest demand for after-hours primary care services was in **children aged 0–4 years** as this cohort represented:
    - 17% of after-hours ED presentations (Category 4 and 5) but only 7% of the population
    - 34% of 13 HEALTH calls.

Annual funding and PHN After Hours Program activities

Total annual funding for the After Hours Program for financial years 2018–19 and 2019–20 is presented in Table 14. Brisbane South funding per capita for was roughly two-thirds of the national average level across all PHNs. The PHN is ranked 19th out of the 31 PHNs in relation to the amount of funding in absolute terms.

Table 14 – Summary of Brisbane South PHN After Hours funding

Financial year	Total After Hours allocated program funding (PHN)	After Hours funding per 1,000 population (PHN)	All PHN After Hours Program funding per 1,000 population	PHN ranking (After Hours funding per 1,000 population)
2019–20	$1,981,385	$1,940	$3,056	19th
2018–19	$1,886,199	$1,847	$2,867	19th

Informed by the Deloitte review and the general needs analysis, Brisbane South PHN's Activity Work Plan's main focus was on identified vulnerable population groups and place-based responses. The 2019–20 Activity Work Plan allocated $1.7m in after-hours funding across five primary activities and projects (see Table 15).

Table 15 – After Hours Program activities

Priority Area	Planned expenditure[1]	
	$'m (2019–20)	%
AH 5.1 CALD Health System Navigation Project	$0.1m	8%
AH 5.2 Domestic and Family Violence	$0.4m	21%
AH 5.3 Homeless Health	$0.7m	44%
AH 7.1 After Hours Response	$0.3m	16%
AH 7.2 ED Avoidance Campaign	$0.2m	12%
Total	**$1.7m**	**100%**

Notes: 1. These figures relate to planned expenditure, which may not be the same as the total amount allocated to the PHN due to carry forward of funding or internal use of funding. Jimboomba MDS project funded from line AH7.1 After Hours Response

Source: Brisbane South Primary Health Network (2019a)

The Jimboomba MDS case study

While the Deloitte review identified Mt Gravatt and Jimboomba as specific target areas for after-hours services, Brisbane South PHN conducted further research and consultation determining:

- Mt Gravatt had access to after-hours GP clinics and a medical deputising service.
- Jimboomba had limited access to after-hours GP clinics and medical deputising services through 13SICK were unreliable.
- ED use in Mt Gravatt was likely heavily influenced by its proximity to the Lady Cilento Children's Hospital.
- Extending operating hours in Mt Gravatt would be challenging due to the location of some clinics (i.e. inaccessible after hours in shopping centres).

As a result, Brisbane South PHN decided to provide funding to support access to an MDS in Jimboomba alone.

The Jimboomba SA3 represents a relatively large geographic area outside of the Brisbane metro and located to the south of the Browns Plains and north of Beaudesert. It includes suburbs such as Logan Village, Yarrabilba, Cedar Vale, Jimboomba and New Beith. This region is expected to see rapid population growth in the coming years, particularly in the suburb of Yarrabilba. Of particular note:

- 28.8% of Jimboomba's population are children, making it the location with the greatest proportion of children and youth in Brisbane South PHN (Brisbane South Primary Health Network, 2018a).
- Within Brisbane South PHN, Jimboomba has the highest number of residents per full-time equivalent GP – 1,213 (average across Brisbane South PHN is 870 residents per full-time equivalent GP).
- Within the PHN, Jimboomba has:
    - The second-lowest concentration of general practices with 2 per 100km^2, where the Brisbane South PHN average is 9 per 100km^2. Three practices are listed on the Healthdirect website with a further two on the periphery of the area.
    - The second-lowest concentration of pharmacies with 1 per 100km^2, where the Brisbane South PHN average is 5 per 100km^2 (Brisbane South Primary Health Network, 2018b).

With respect to the after-hours period, stakeholders consulted observed that:

- There are limited after-hours GP clinic services available.
- The two nearest hospitals are the Lady Cilento Children's Hospital (50km from the town of Jimboomba) and the Logan Hospital (30km).
- Prior to the after-hours funded program, 13SICK provided an MDS to Jimboomba, however, the service was unreliable and suffered from long waiting times due to travel and distances involved Brisbane South Primary Health Network, 2018b.

Service design

13SICK (National Home Doctor) is an MDS funded to operate in the after-hours period, providing urgent care on weekdays (overnight to 8 am), Saturday afternoons, and all day on Sunday and public holidays). It provides a bulk-billed service. Calls are received into a Queensland triage centre and assigned as appropriate. Post-visit, clinical notes are electronically sent to the patient's normal GP within 24 hours.

All services were engaged through an existing GP as the MDS model does not allow for direct marketing/approach to patients.

The 13SICK Jimboomba service commenced in early 2019. Both the commissioned service provider and the PHN reported delays in commencing communications activities, which pushed back the start of the program. Awareness activities were shared as follows:

- 13SICK developed relationships with GP clinics and the clinics themselves were able to communicate and raise awareness of the service to patients.
- the PHN undertook responsibility to raise community awareness.

As part of the Brisbane South PHN After Hours Program, 13SICK received a subsidy from the PHN to cover the additional cost of vocationally registered doctors visiting patients in the region, effectively eliminating the service fee typically levied by the MDS from the treating doctors in its workforce. This had the effect of allowing the doctors to collect the full fee from Medicare for each service provided in the Jimboomba region. While 13SICK previously covered this geographic region, it was in a secondary capacity, and the distances and time – 40 minutes each way – to conduct visits were a significant barrier to the doctors accepting referrals into the region. By eliminating the service fee paid by doctors to the MDS, the PHN funding effectively provided an economic lever for the MDS workforce to engage and provide supports to patients in Jimboomba. It was intended to have the effect of making the MDS service economically viable, where before it was generally fairly marginal because of the limited volumes.

The planning intent was that after a period of awareness raising and service provision, the volume of services would increase to a level that would be self-sustaining for the MDS.

What impact has the program had?

The PHN reported that during the funded period, client numbers did not reach the level of demand required to guarantee sustainable and timely servicing post-funding. Funding for the service ceased at the end of March. The final month of operation of the service had lower volumes than previously and may have been impacted by the COVID-19 pandemic.

Table 16 presents data for 2019–20, showing a 41% reduction in enquiries in January to June 2020 compared with the July to December 2019 period. Absolute numbers of patients seen also fell in the second half of the year, however the number of patients seen was a higher proportion of all patient enquiries in the period. The proportion of patients seen increased to 53%, as the demand for services reduced and the MDS workforce accepted more call-outs to the Jimboomba region.

Table 16 – Summary of 13SICK activity data

	July – December 2019	January – June 2020	TOTAL 12 month period
Enquiries	532	315	847
Patients seen	187	166	353
Seen %	35%	53%	42%

In terms of call volumes, 80% of callouts booked from 13SICK are booked by 8 pm. The MDS organises its staff for this level of demand, with primary doctors working 6 pm to midnight on weekdays.

Brisbane South PHN is finalising an evaluation for this commissioned program. Evaluation findings to date indicate the program has aided relationships between GPs and after-hours GPs and improved timely access for patients to after-hours GPs.

The commissioned service provider, 13SICK, reported that since commencement they have observed an 18% increase in patients seen in the Jimboomba area and a 27% improvement in converting enquiries in the region to patients seen (as opposed to cancelled due to extended wait times and/or doctor unavailability in the region).

Given Brisbane South PHN's initial design intent, it is important to note that 28% of the patients seen since commencement were aged four years old or under.

Data collected from patient surveys (n=56) in March 2020 reported that 82% of patients were seen within 3 hours, with an average waiting time of approximately 2.3 hours. This survey finding supports the anecdotal feedback provided by consumer representatives indicating that long waiting times can still be experienced. The GP practices consulted did not feel the 13SICK service was well utilised. A rough estimate suggests the MDS saw, on average, about one patient a week from each practice.

The service recorded patient outcomes in terms of onward referrals. As an illustration, data provided for March 2020 showed:

- 38% of patients were referred to a pharmacy for support
- 31% were referred back to their GP and
- 29% were referred to attend the ED.

Key barriers and potential impediments for this funded program were identified as follows:

- Providing sufficient incentive for MDS services to travel to the Jimboomba area for only a few patient calls.
- The ability to build service awareness was seen as a limiting factor.
- Lack of awareness of the service with aged care facilities, medical centres, hospital and pharmacies as an alternative care option for patients.

Improving the program

Opportunities to improve the program were identified as follows:

- The general limitations on the ability to promote MDSs and increase awareness has limited the growth and volumes of the MDS. While the rules around advertising are intended to ensure patients access after-hours care through their GP, it does mean that patient awareness is limited by how well GP practices promote the service. Well-established services may not require significant promotion. However, those in the establishment phases face long lead times before sustainability is realised. If this model is

to become viable it need more joint engagement work between the PHN, the practices and the service provider.

- Offering telehealth consults through the MDS rather than relying on a home visit service has proved a viable option since funding for the service ceased due to the introduction of the telehealth MBS items. However, there may still be a requirement for face-to-face consultations.
- In Jimboomba, there are fewer practices per head (1,213 residents per GP versus the PHN average of 870 residents per full-time equivalent GP) and limited after- hours provision. Brisbane South PHN appears to have an average level of take-up of the PIP program compared with other major cities (see Figure 12 in main report). However, the challenge in this area is that there are fewer GPs per head and a perception that the incentives available are not leading to availability of services. Further work is needed to understand if the barriers relate to the size and nature of incentives or whether there are other contributory factors.

Stakeholders consulted and survey responses

Table 17 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other
PHN	4		
Commissioned providers		3	
GP Clinics			1
GP Representative			1
Total	**2**	**3**	**2**

Table 18 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider surveys	3

5 Perth South PHN

Case study scope and focus

The Perth South PHN case study was **program-based** and focused on the **50 Lives 50 Homes supported by the After Hours Support Service**. The 50 Lives 50 Homes project is a multi-agency program that includes a homeless healthcare initiative with a GP clinic that provides street outreach and in-reach to homeless people. This is supplemented by the PHN-funded After Hours Support Service. This service receives annual funding from the PHN After Hours Program of $957,423, representing 57% of the total Perth South PHN after-hours budget.

What were the key observations from this case study?

What we learnt:

- **There can be after-hours service gaps in metropolitan PHNs even where supply of after-hours GP clinics is appropriate for the majority of the population**. Like many other major cities, Perth South PHN identified the homeless population as having a high need for primary care services and a group that are intensive users of ED and hospital services.
- The after-hours support service commissioned under the After Hours Program is a small element of a much larger 'housing first' initiative that includes a homeless healthcare service. The service is delivered to the very highest-need group of homeless people with significant health issues. **The service represents a significant investment from Perth South PHN to a relatively small but high-need group.**
- Mainstream services are not designed to meet the needs of some patients and **distinctions between in-hours and after-hours mean very little for some vulnerable groups.** More flexible and responsive approaches are needed.
- The success of this after-hours support service is built on a broader initiative that has brought together agencies from across the charitable, state, health and other sectors. **Strong relationships, collaboration and effective joint work are important prerequisites, as is the need for PHNs to be effective commissioners**. **Using the program to link and extend the existing homelessness services into the after-hours period has been very beneficial.**
- **There are often critical ingredients that come together to deliver good outcomes.** As well as the effective multi-agency work, there were key individuals who influenced and championed the needs of this client group as well as a charitable organisation that was willing to take on the 'backbone' role.

Perth South PHN supports primary care services across the southern part of Perth city, Fremantle, and the Mandurah, Murray and Waroona region. The resident population is just under 1 million (928,842) and it is spread across 5,148 square km (Department of Health, 2018b). Perth South makes up 35% of the Western Australian population (WA Primary Health Alliance, 2019).

According to the Modified Monash Model classification, the majority of the PHN's population falls within categories 1 and 2 but the rural areas to the south east of the city are classified as category 5.

The three PHNs covering Western Australia were brought together under a single organisation called the Western Australia Primary Health Alliance. The Alliance oversees the commissioning functions of the three PHNs and adopts a centralised approach where there are benefits, with a localised approach adopted when required. The boundaries of the Perth South PHN are illustrated in Figure 7.

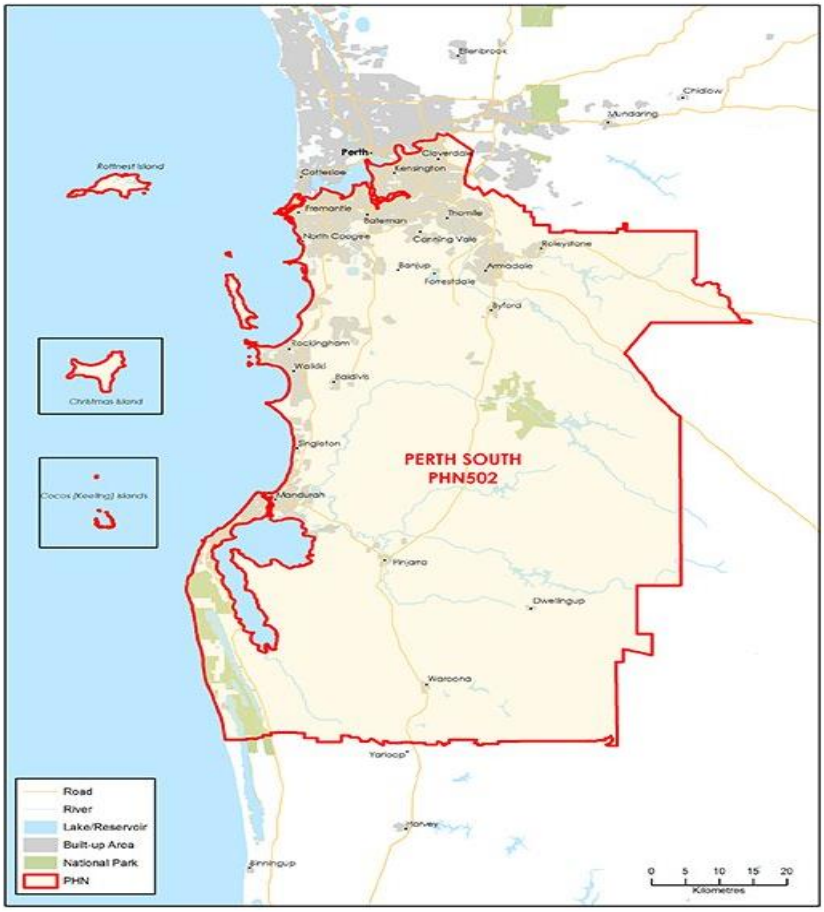

Figure 7 – Map of the Perth South PHN

Source: Department of Health (2015)

In comparison to the 31 PHNs in Australia (Australian Bureau of Statistics, 2016a), Perth South PHN is ranked:

- **24th** in terms of geographic area covered
- **11th** in terms of the total population supported
- **18th** in terms of Aboriginal and Torres Strait Islander peoples supported.

Figure 8 presents data on after-hours GP attendances and ED presentations. This shows that Perth South PHN has close to average levels of both measures. Relative to other PHNs, usage of after-hours GP care was slightly lower than the national average but ED presentations were slightly higher. In particular, the PHN is ranked:

- **11th** of 31 PHNs for GP after-hours services with **468** per 1,000 residents (national average of **490)**
- **20th** of all 31 PHNs for after-hours low-urgency ED attendances with **58** per 1,000 residents (national average of **56**).

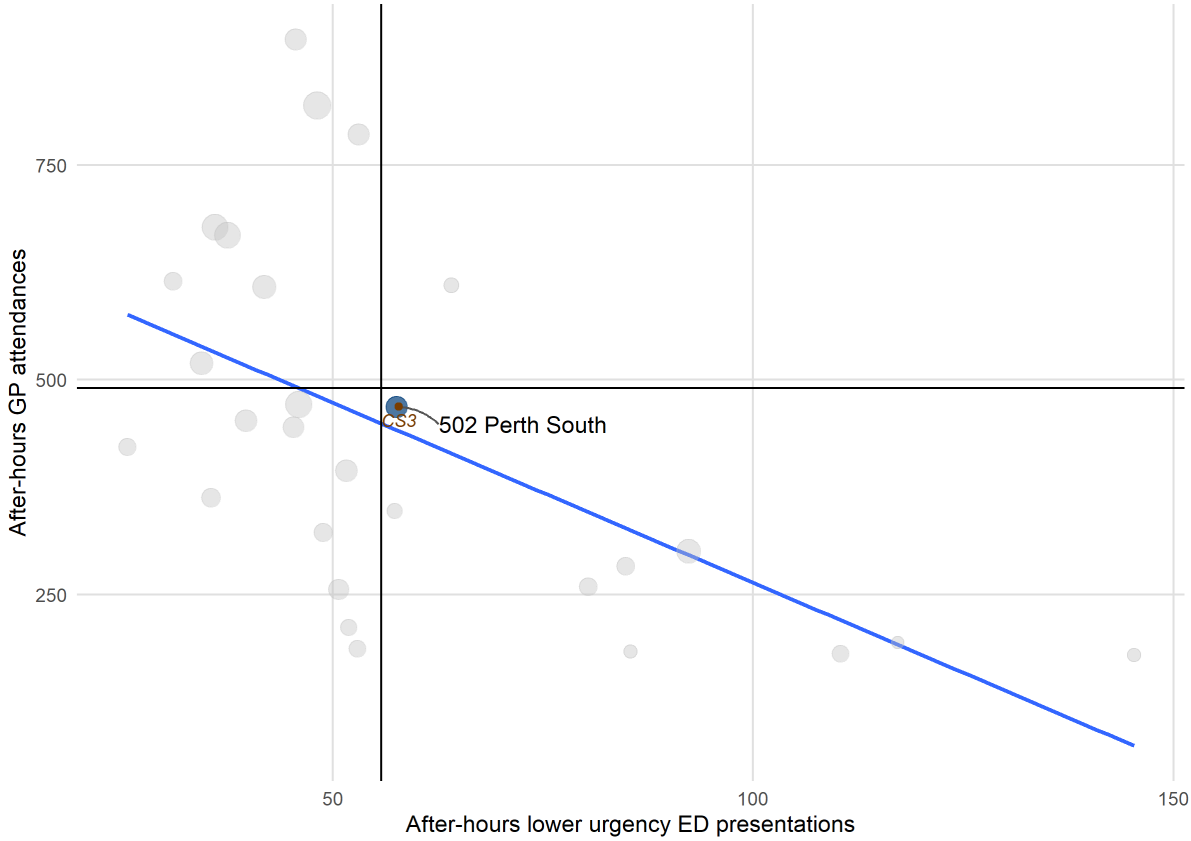

Figure 8 – GP after-hours and low-urgency presentations by PHN, Perth South PHN, 2018–19

Sources: ED – Australian Institute of Health and Welfare (2020b); GP AH – Australian Institute of Health and Welfare (2020a)

Key population and health data relevant to the understanding of the case study are:

- The PHN is geographically aligned with two of the Western Australia LHNs (East and South Metropolitan).
- Provision of after-hours primary care services in the metro area is generally good.
- The area is very much 'average' for Australia in relation to funding, ED attendances and GP after-hours usage, relative to PHNs nationally.
- There are pockets of increased need within the metro area but also across the PHN in some of the surrounding towns such as Armadale, Rockingham, Pinjarra and Mandurah.

Health services within the case study service setting/locality

After-hours provision in Perth South PHN was generally seen as good with many metro area GP practices offering after-hours services. There are specific gaps in some areas, such as Armadale, where service coverage is poor, and as a result, the PHN is funding an after-hours service in the area. The PHN has also placed a heavy emphasis on the needs of vulnerable populations.

Perth South PHN approach

Perth South PHN inherited some activities from the Medicare Local and had to move quickly to put things in place when the PHNs were established. The PHN rolled forward contracts for 12 months but some of these activities have since been decommissioned. Only one activity

remains from 2015, which is the urgent-care centre in Armadale where there are limited GP services.

There has been change over time. Perth South PHN commissioned a needs assessment from Curtin University. The report identified that the heaviest users of after-hours services were:

- children under 5 years
- people aged over 65 years
- vulnerable and disadvantaged populations, e.g. persons with chronic conditions, a mental health diagnosis, homeless people, Aboriginal populations.

These groups have formed the basis for the priorities of the PHN, and feedback from clinical and consumer networks has supported this decision. Some services were commissioned to support other programs so they are stretching into the after-hours period. Some other activities were picked up and funded through ongoing funding programs. This provided an opportunity to invest in new services.

Perth South PHN is working with the state health department to establish urgent-care centres, an election pledge now being rolled out. These urgent-care centres are being developed using a GP urgent-care network approach with a view to using existing capacity. Work is ongoing with the piloting of this approach, which will supplement after-hours provision.

Perth South PHN's overall approach has been to focus on a limited number of high-impact activities. The needs assessment and clinical and consumer engagement suggested the greatest impact, and therefore focus, should be on vulnerable populations.

Total annual funding for the After Hours Program for the past two financial years is presented in Table 19. This indicates that on a population basis, Perth South PHN receives a lower-than-average level of funding per capita but has higher funding than a third of the PHNs.

Table 19 – Summary of Perth South PHN After hours funding

Financial year	Total After Hours allocated program funding (PHN)	After Hours funding per 1,000 population (PHN)	All PHN After Hours Program funding per 1,000 population	PHN ranking (After Hours funding per 1,000 population)
2019–20	$1,674,914	$1,803	$3,056	21st
2018–19	$1,685,580	$1,815	$2,867	21st

Perth South PHN developed 5 key priority areas as part of its after-hours primary health care response, summarised as follows (Perth South Primary Health Network, 2019):

- Reduce rates of potentially preventable hospitalisations by working with primary care to target areas with high rates.
- Reduce non-urgent ED attendances and improve access to alternative services.
- Improve the management of chronic conditions for ageing populations, including a reduction in unnecessary hospitalisations, an increase in palliative care services and increased awareness of programs and services.
- Increase access to community-based early intervention and harm reduction services in areas with high rates of harmful alcohol and other drug use.
- Engage with primary health care providers and Local Hospital Networks to improve transitions of care, care coordination and service linkages.

These priorities are reflected in the Activity Work Plan shown in Table 20.

Table 20 – Perth South PHN After Hours Program activities and allocated funding

Priority Area	Planned expenditure 2019–20		Represented in case study
	$'m	%	
Armadale after-hours service	$0.15	7%	
After-hours support for disadvantaged/vulnerable and homeless populations	$1.00	44%	✓
After-hours integrated mental health, suicide prevention, and drug and alcohol treatment services	$0.40	18%	
Advance care planning and My Health Record collaboration	$0.14	6%	
Urgent-care clinics public awareness and education campaign	$0.59	26%	
Total	$2.28	100%	
Comprising:			
2019–20 funding allocation	**$1.67**		
Funds carried forward from prior periods	$0.61		
Total	$2.28		

Service design – 50 Lives 50 Homes and After Hours Support Service

The 50 Lives 50 Homes initiative provides long-term housing and support to some of the most vulnerable people sleeping rough in Perth. The project is a multi-agency program that includes a homeless health care service with a GP clinic that provides street outreach and in-reach to the homeless service. This is supplemented by the PHN-funded After Hours Support Service. The 50 Lives 50 Homes project was one of the earliest to be commissioned by Perth South PHN, and well established by the time the PHN funded the After Hours Support Service.

People are prioritised to receive services using the Vulnerability Index – Service Prioritisation Decision Assistance Tool (OrgCode Consulting, n.d.). The 50 Lives 50 Homes project is a 'housing first' initiative, aiming to secure long-term housing and providing wraparound support to keep the person or family in their home. The idea behind the program is to increase the use of non-crisis health input and improve people's physical and mental health. The After Hours Support Service logic model is shown in Figure 9.

The After Hours Support Service is made up of two teams comprised of two nurses and two community workers. They operate from 3 pm – 11 pm on weeknights and 10 am – 4 pm on weekends. Starting on weekdays before the after-hours period commences allows for a handover from the daytime staff. Referrals are taken from the homeless healthcare team or from the housing provider. The After Hours Support Service is seen as an important element of support and a crucial factor to the success of keeping people housed.

The combination of nurses and social workers allows clients to be seen both for social issues and to provide opportunistic health checks. For many people, but this group especially, health needs are not easily separated from social, emotional and other needs.

The group of people being supported have a range of health care needs: 72% of the clients have mental health conditions, 55% have chronic disease conditions and 37% have alcohol or drug addiction issues. Over a quarter of the clients have three or more chronic conditions.

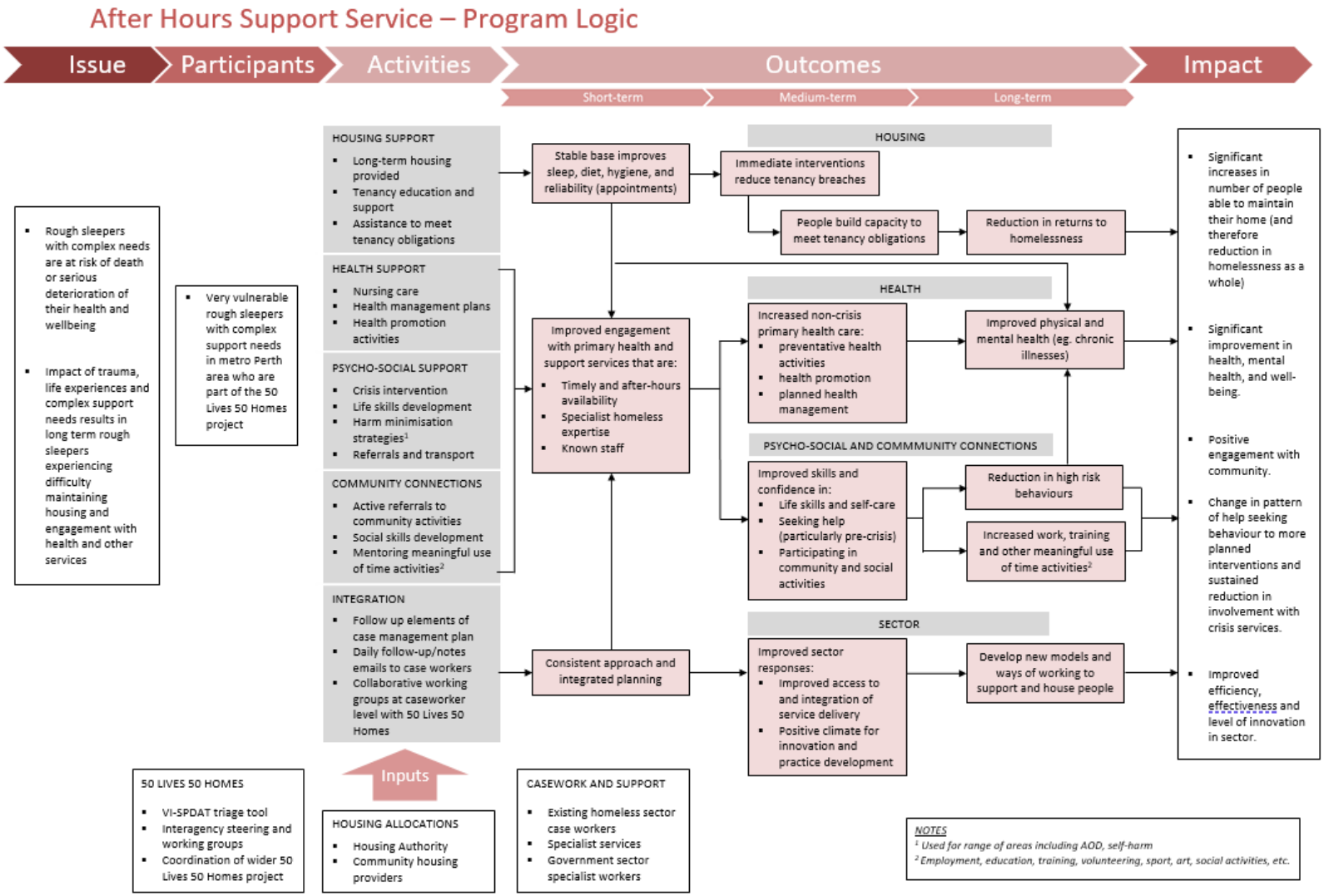

Figure 9 – After Hours Support Service logic model

Source: 50 Lives 50 Homes

What impact has the program had?

Table 21 presents a summary of the activities of the After Hours Support Service for 2019–20.

Table 21 – Commissioned services, 2019–20

Activity indicator	Measure	Volume
Number and percentage of 50 Lives 50 Homes clients supported by the After Hours Support Service	Number of clients of the total number housed (269 people)	124 (46%)[1]
Number of instances of support provided after hours	Number and type of support instances	4,322[2]
Number of planning and assessment sessions provided	Number of sessions	1,827
Number of referrals	Number of referrals	1,097

1. In addition, outreach support was provided to 23 unhoused people; 2. This includes crisis support, basic needs support and emotional and mental health support.

The reporting process to the PHN includes outcome assessments reporting on patient/client experience and service providers' and stakeholders' perceptions. The reports provided were detailed and clear.

University of Western Australia evaluation

The 50 Homes 50 Lives program (including the After Hours Support Service) has been subject to an ongoing evaluation program conducted by the University of Western Australia (Vallesi et al., 2020). Because the After Hours Support Service is part of the wider project, it is not easy to separate the impact of the after-hours element from the rest of the program. The evaluation considered a range of outcomes, including housing and criminal justice outcomes as well as health.

The University of Western Australia evaluation assessed a cohort of 97 clients housed for at least one year, 50 clients two years after being housed, and another 90 clients following one year being housed. As identified by this evaluation, rates of schizophrenia and depression, alcohol and drug dependency, and physical conditions such as asthma, diabetes, chronic pain were high among the cohort. The evaluation also highlighted the rate of Hepatitis C infection, where the prevalence in this group was 46 times higher than the general population. The report draws attention to the high rates of premature mortality and accelerated ageing that is commonly seen in people experiencing homelessness.

The average number of ED presentations per person in the year preceding being housed was 5.2, with an average of 2 inpatient admissions and an average length of stay of 11.2 days. Hospital usage was lower in the 12–36 month period prior to being housed compared to the 12 months before being housed.

The report also showed a reduction in mean ED presentations by those who had been housed under the program. For the group that had been housed for 2 years, the average number of ED presentations fell by 2.2 per person compared with the 2 years prior to being housed. For the group that had been housed for one year, the reduction in ED presentations was 2.9 per person per year. For both groups, the number of people with zero presentations increased.

This reduced ED usage equates to costs savings of $1,877 to $2,402 per person for the one-year and two-year housed groups respectively. Clients also experienced a reduction in ambulance arrivals and psychiatric inpatient days. However, the number of inpatient days for the 2-year housed group increased by a total of 74 days (across all 50 clients) and $4,305 on average per person over the two years, whereas the one-year group had fewer inpatient

days and the cost reduced by $4,182 on average per person. The authors were unsure why the inpatient days increased for the 2-year group. The authors speculate that it may be associated with long-term condition deterioration, which would happen regardless of their housing and other circumstances. They also note that with a small cohort of 50, and with some patients requiring very intense and lengthy care, this may have the effect of skewing the overall findings.

Overall, healthcare costs fell on average by $10,050 per person for the one-year cohort, which equated to almost $1 million in total. For the two-year group, despite the increased inpatient days, there was still an average saving of $466 per person, or $23,290 in total.

The report described the After Hours Support Service as a critical part of the service and the recent additions to the team means that the service can cover a larger area. Home visits made up 64% of contacts, with the remainder conducted via phone. The authors point to the importance of the wraparound after-hours support, stating that after-hours support in any future housing-first initiatives 'should be considered essential'.

Other feedback and stakeholder views

Stakeholders were universally positive about the program and the after-hours component. It is clear that one of the contributory factors to the overall success of the program has been the multi-agency approach to the housing-first initiative. The importance of having an agency providing a 'backbone' function that facilitates and supports the multi-agency activity and establishing after-hours provision within a wider program appears to have been highly effective.

An ED consultant from one of the Perth hospitals noted that tackling homelessness is essential in reducing pressure on ED services and improving health and life outcomes for this group. The homeless healthcare service is a key element of the overall provision and it is questionable whether the after-hours support service could function adequately without having the homeless health service in place.

Other agencies and service providers involved in youth and other related services were also very positive about the after-hours service.

While it was acknowledged that Perth South PHN consulted extensively to determine its priorities in the needs assessment, there was also a view that the PHN could broaden its remit from its focus on high-impact areas and use some of the funding towards coordination of mainstream after-hours services.

The Perth South PHN was seen as being effective and well engaged. It was described by stakeholders as supportive and collaborative and 'actively interested' in outcome measurement as part of the commissioning process.

All of the providers of commissioned services (After Hours Support Service and others) under the After Hours Program in the Perth South PHN regarded their service as 'very successful' in improving access, efficiency and effectiveness of after-hours care. One of the success factors noted by some of the stakeholders was linking the program to pre-existing or other related services that had the effect of reducing overheads, increasing community acceptance, and connecting services and organisations in a very positive way.

Improving the program

The following opportunities for improvement were identified:

- Measurement of impact and outcomes were identified as necessary components of commissioned services. However, service providers noted that commissioners need to be aware of the reporting burden placed on providers, especially where they are dependent on multiple funding sources.

- Longer funding periods, for example 5 years, would provide stability for the services, prevent high levels of staff turnover, and provide a greater opportunity for service improvement.
- Services are limited in their capacity to provide specific services for people with chronic illnesses, alcohol and drug dependency, and mental health issues.

Stakeholders consulted and survey responses

Table 22 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other
50 Lives 50 Homes		1	
Other service providers/stakeholders			2
ED staff			1
Homeless Healthcare GP			1
Clinical council			1
PHN	1		
Total	**1**	**1**	**5**

Table 23 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider survey (case study providers)	1
Commissioned service provider survey (other commissioned providers)	2

6 Adelaide PHN

Case study scope and focus

The Adelaide PHN case study is a **program-based** study, focused on **the Lived Experience Telephone Support Service (LETSS)**. LETSS provides an after-hours mental health telehealth services, staffed by peer workers with a lived experience, across the entire PHN region. Services included supported service linkage and informal counselling.

What were the key observations from this case study?

What we learnt:

- While the Adelaide PHN was relatively well served by GPs in the after-hours period, the needs analysis identified **significant gaps in primary care to effectively support people with mental health issues**. These gaps existed in both the in-hours and after-hours periods.
- The LETSS service addresses a gap in service after hours and **contributes to the development of a stepped model of primary care** for people with mental health needs living in the Adelaide PHN region.
- Critical success factors for the LETSS include:
- A trained, paid, peer workforce with lived experience
- A focus on non-crisis needs, including service links and informal counselling
- Strong relationships to escalate to and receive referral from crisis support services
- No referral or appointment required, with minimal waiting time
- Unlimited access, with no time or contact limit.
- LETSS volumes have grown and **the service is considered by callers and referrers as being effective** in meeting client need. The service reported that it **is operating at full capacity**. Stakeholders expressed a desire to have LETTS:
    - extend its existing after-hours operating hours
- expand and provide an in-hours service
- expand to provide services in Country SA PHN.
- **Few callers (3%) reported that they would have attended the hospital**, called an **ambulance or visited a GP** if LETSS was not available.
- LETSS is providing an effective model of care that appears to be **meeting an unmet need** that sits between acute care, crisis care, other call centres and more traditional primary health care.

Locality overview

The Adelaide PHN region encompasses 17 local government areas that make up the Adelaide metropolitan area. It extends from Sellicks Hill in the south to Angle Vale in the north, and from the beaches in the west to the foothills in the east (see Figure 10). The PHN supports 70% of the South Australian population in an area covering just 0.2% of the state. It had an estimated resident population of around 1.2 million in 2019 and a population density of 8.03 persons per hectare (Adelaide Primary Health Network, 2020).

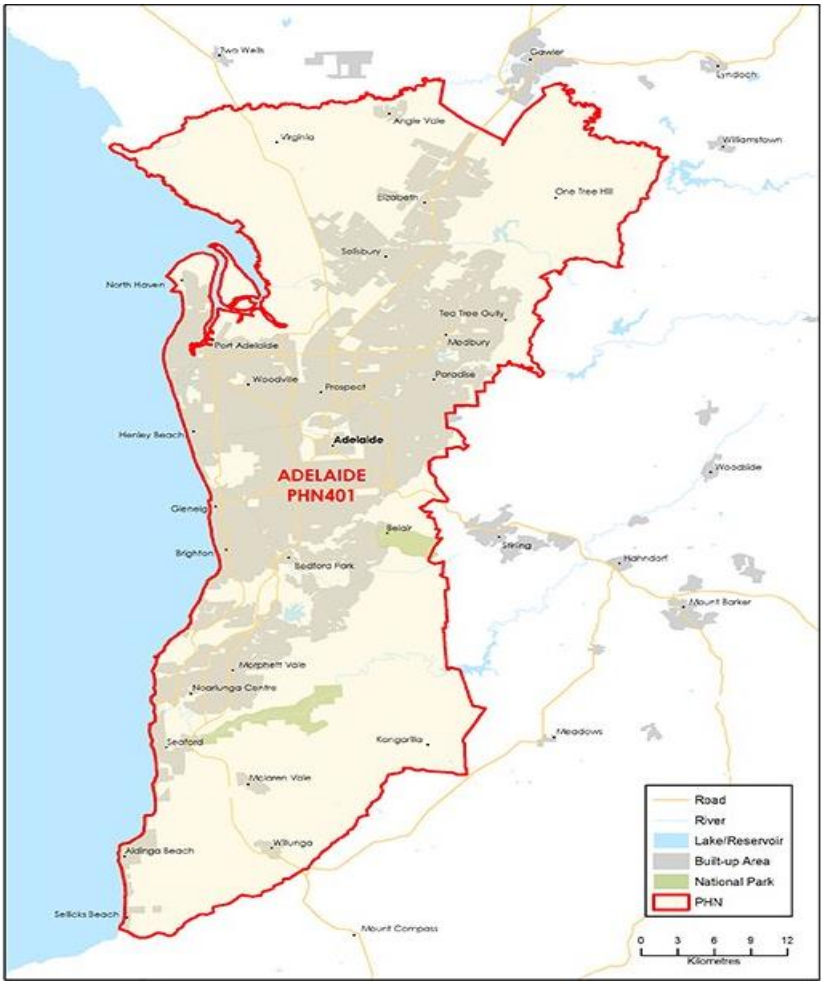

Figure 10 – Map of the Adelaide PHN

Source: Department of Health (2015)

Key health population, health profile and service data for Adelaide Primary Health Network, 2018[1] includes:

- About 1.5% of the population identify as being Aboriginal and Torres Strait Islander.
- Median weekly household income in the PHN is $1,246 (Australian median is $1,431).
- There are 10 public hospitals (3 in the north, 5 in the central area and 2 in the south).
- There are more than 300 general practices (28% in north, 44% in central, 28% in south) and over 300 pharmacies (29% in north, 46% in central, 25% in south).
- 11% of adults saw a GP after hours in the past 12 months.
- 85% of GP attendances were bulk billed.
- About 170,000 people aged 15 years or over have a long-term mental or behavioural problem. This is approximately 14% of the population (Adelaide Primary Health Network, 2016).
- Nearly 18,000 ED presentations during 2018 were for a mental health condition, representing approximately 5% of total ED attendances.

Under the Modified Monash Model, almost the entire PHN is classified as Category 1 (Metropolitan) with a small proportion as category 2 (Regional Centres).

In comparison to all 31 PHNs in Australia (Australian Bureau of Statistics, 2016a), the Adelaide PHN is ranked:

- **6th** largest in terms of the total population supported.

[1] https://profile.id.com.au/aphn

- **23rd** in terms of the proportion of Aboriginal and Torres Strait Islander people supported.
- **12th** in terms of the proportion of the population aged 65 years or older.
- Figure 11 suggests that after-hours primary health care in Adelaide PHN is well utilised relative to other PHNs. In particular, the PHN is ranked:
- **8th** for GP after-hours services with **608** per 1000 residents (national average of **490**).
- **8th** lowest for after-hours low-urgency ED attendances with **42** per 1000 residents (national average of **56**).

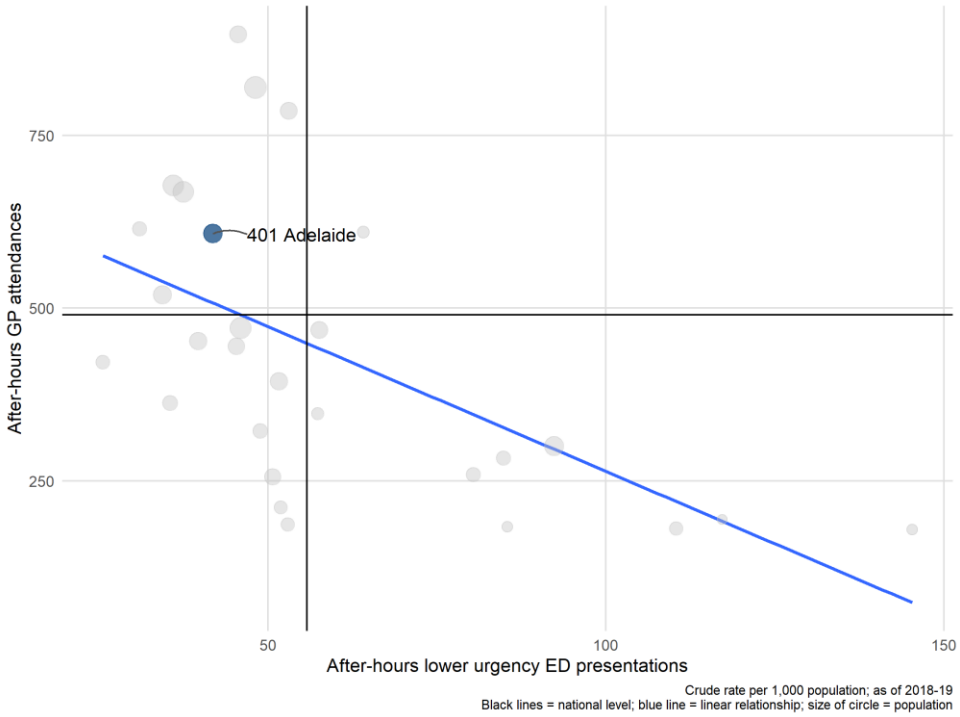

Figure 11 – Adelaide PHN GP after-hours services vs after-hours low-urgency ED attendances, 2018–19

Sources: ED – Australian Institute of Health and Welfare (2020b); GP AH – Australian Institute of Health and Welfare (2020a)

The Adelaide PHN approach

The Adelaide PHN needs assessments over the past 3-5 years have supported service developments that build around GP practices, rather than directly supporting general practices to provide specific after-hours services. For example, LETSS is an independent service that addresses service navigation and health literacy needs within mental health care.

The Adelaide PHN needs assessment processes involved the triangulation of available data from the ABS, SA Health and other sources, and consultation with clinical and community advisory councils. The assessment highlighted mental health as a priority area, with high rates of psychological distress in the community, and, in turn, a high potential to divert preventable hospital admissions.

Mental health access was further highlighted by a GP round table, noting that urgent mental health care was difficult to access and mental health services as a whole often involved long wait times.

After Hours funding

Total After Hours Program funding over the past two financial years is presented in Table 24. Adelaide PHN was funded at lower rate by population than the national average.

Table 24 – Summary of Adelaide PHN After Hours funding

Financial year	Total After Hours allocated program funding (PHN)	After Hours funding per 1,000 population (PHN)	All PHN After Hours Program funding per 1,000 population	PHN ranking (After Hours funding per 1,000 population)
2019–20	$2,223,599	$1,879	$3,056	20th
2018–19	$2,254,599	$1,906	$2,867	18th

The Activity Work Plan for 2019–20 allocated the PHN's After Hours funding across six main programs of activities and projects. Three of the six directly address mental health after-hours access services and supports, representing over 60% of the total funding allocation (Adelaide Primary Health Network, 2019).

Table 25 – Adelaide PHN Activity Work Plan 2019–20

Priority area	Funding allocated		
	$'m (2019–20)	%	Mental Health
AH1. After Hours Consumers Awareness Resource	$0.1m	1.2%	
AH2 Extended Primary Care for Residential Aged Care Facilities (Camellia Project)	$0.1m	3.6%	
AH3 Northern and Southern After Hours Walk-in Clinics	$0.4m	19.0%	✓
AH4 Lived Experience Telephone Support Service	$0.5m	25.0%	✓
AH5 Northern and Southern Paediatric Partnership Program	$0.3m	16.7%	
AH6 After Hours Extended Mental Health Clinical Services	$0.3m	16.2%	✓
AH7 After Hours Needs Assessment Process – Options and Opportunities	$0.4m	18.2%	
TOTAL	**$2.1m**	**100%**	

Note: Total not reconciled to total funding of $2.2m.

Aligned with the Commonwealth Government policy directions towards a stepped model of care for mental health – providing access to varying levels of primary care depending on the assessed level of need of a person – the Adelaide PHN released a request for proposal for service providers in the region to deliver primary mental health care services across all levels of primary care. After a comprehensive assessment process, the PHN commissioned a range of services, including:

- strengthened access to specialised clinical services
- access to walk-in services in the northern and southern suburbs
- helpline provision of service navigation, health literacy and ongoing support.

The Lived Experience Telephone Support Service

With Adelaide PHN's agreement, this case study focuses on the After Hours Mental Health Lived Experience Telephone Support Service (LETSS).

LETSS was identified by Adelaide PHN as an initiative that would address a range of priorities identified in the PHN's needs assessment, including:

- Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations.
- Lack of consumer and provider awareness about existing health care services.
- The need to improve education of preventive health measures for consumers and professionals.
- Awareness of and timely access to appropriate services (including after-hours services) for vulnerable population groups, particularly Aboriginal and Torres Strait Islander people, children and youth, people with a disability, older people, palliative care patients, and their carers.
- Difficulty in identifying and accessing appropriate mental health treatment services.
- Increase awareness of appropriate mental health services to health professionals, community and carers through the provision of information and resources.

Service design and outputs

LETSS was jointly developed by the Adelaide PHN and the Mental Health Coalition of SA, employing a co-design process with people who have lived experience of mental health issues. With the development of a regional stepped primary mental health care service delivery plan, the program was designed to address the expressed needs of people experiencing mental health issues. The resulting service model is designed to serve three main functions:

1. Information:

- General information, guidance and advice about mental health and other services, mental health conditions and other associated topics.

2. Navigation:

- Direct and assist access to relevant mental health and other services.
- Assist callers to understand the service landscape, its entry points and eligibility criteria.
- Assist callers in understanding the referral processes, providing tips on how to avoid barriers and pitfalls to accessing services.
- Coordinate user access to services in real time.
- Facilitate referrals, including the use of warm referrals.
- Signposting callers so they receive services and assistance appropriate to their needs.

3. Support:

- Listening to and understanding callers, as well as providing brief intervention and informal counselling.
- Providing emotional support during times of distress.
- Providing advocacy.
- Providing coaching and mentoring.
- Supporting care implementation, recovery and wellness plans.
- Assisting patient attendance at appointments.
- Provide follow-up support, including scheduled call backs, welfare checks, and connection to services.

LETSS is delivered as a one-to-one, non-clinical telephone service that leans on the lived experience of a peer-support mental health workforce. The entire LETSS peer workforce has a lived experience of mental illness, whether personal or as a carer.

The lived experience is one that provides an in-depth understanding of their clients, which is further supported by peer workers' certification and training. Peer workers must hold a Certificate IV in Mental Health or Mental Health Peer Work as a minimum, but often have additional qualifications in nursing or social work. The aim is for callers to feel understood and respected by the support workers who can engage honesty and authentically via a common lived experience. While some services and programs engage a peer workforce on a voluntary basis, peer workers engaged by LETSS are paid under the appropriate award.

The service operates seven days a week only in the sociable after-hours period of 5 pm to 11.30 pm, but links and refers to NGOs and State- and Commonwealth-funded services for follow-up during normal business hours.

Access to the service is via a dedicated toll-free (mobile and fixed line) telephone number, and the service also supports access via videoconference and webchat. LETSS also conducts outbound calls for wellbeing checks and follow up. While callers may be referred to the service, referrals are not necessary.

Partnerships and pathways

LETSS collaborates actively with local health networks across metropolitan Adelaide (including EDs and the mental health triage service), police services and other social and community service providers (e.g. covering mental health, drug and alcohol, disability, youth, domestic violence, CALD, Aboriginal and Torres Strait Islander, local government) in the region. Discussions with representatives of selected organisations indicated that LETSS was well-respected and trusted, which was further evidenced by formalised referral pathways and the direct promotion of the LETSS service to clients.

For example, the establishment of a formalised step-up, step-down pathway between LETSS and the SA Mental Health Triage service exists and includes a 'warm' handover facility. This represents around 20% of referrals to LETSS. The SA Health Mental Health Triage Service operates 24 hours a day, 7 days a week. This service:

- is the main point of access into mental health services
- can provide advice and information in a mental health emergency or crisis situation
- is staffed by mental health clinicians
- will assess and refer to acute response teams where appropriate.

Stakeholders noted that information on LETSS is provided to individuals who attend an ED or are admitted to hospital following a mental health presentation. Similarly, SA Police indicated LETSS call line details are provided to those involved in mental health-related call outs.

Arrangements with national telephone or digital support services exist, including SA Police 131 444 call centre, which has information to refer appropriate callers to LETSS. Formalised follow-up pathways also exist for some other NGOs and State- and Commonwealth-funded services (e.g. Sonder, Anglicare).

LETSS also offers training and vocational experience opportunities for pre- and post-graduate students in relevant fields, for example those studying Certificate IV in mental health or mental health peer work.

What impact has the program had?

Stakeholders reported that LETSS:

- Addressed an after-hours service gap in services for people presenting with less critical or serious mental health.
- Provides access to practical advice and support to people navigating the system or in need of a brief intervention or informal counselling.
- Receives favourable feedback from providers and the community.
- Has been effective in improving access and effectiveness of primary mental health care.
- Has successfully implemented the service design and is meeting its service objectives.

Call volumes for the service have consistently grown since the service was established in the second half of 2018 (see Figure 12).

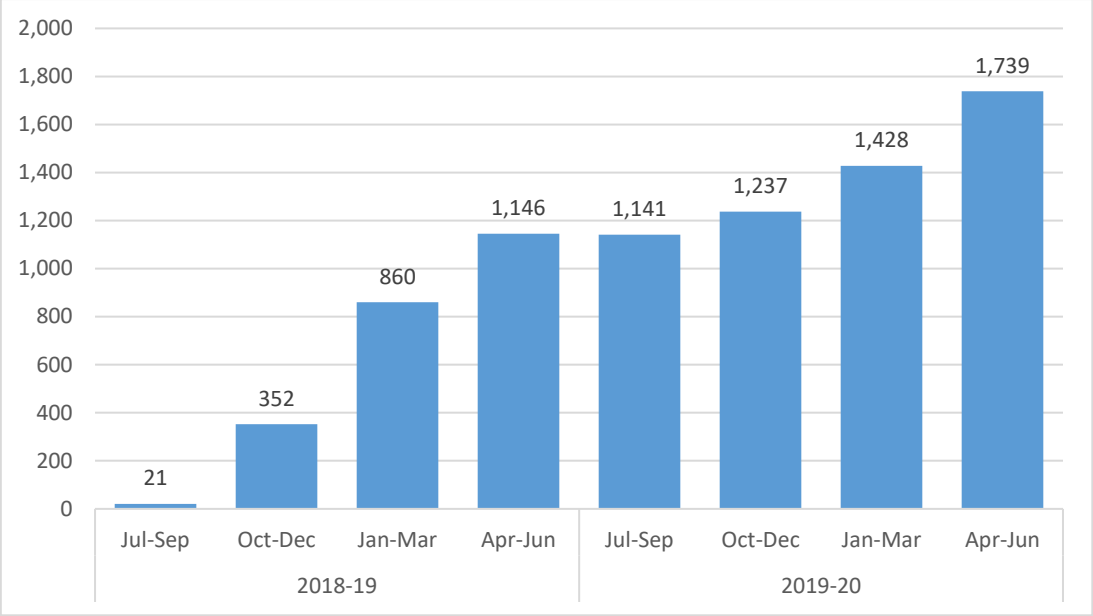

Figure 12 – Total number of LETSS contacts

The most recent quarterly report available (1 April 2020 to 30 June 2020) reported a 21.8% growth in call volumes in the previous quarter. There were more than 5,500 calls from more than 350 people in the past 12 months, equating to about 110 calls a week or 15 calls a night.

Figure 12 shows continual growth since the program's inception, with stakeholders commenting that the service was starting to become resource-constrained due to its current budget. Nevertheless, it was noted that the service had the necessary workforce for further expansion and that they had the capacity to undertake the required education and training, which could be provided directly by LETSS.

Other KPIs of interest from January 2020 to 21 June 2020 show:

- Self-referrals represent 48.6% of all referrals (see Figure 13).
- 88% of contacts are for support (informal counselling and brief intervention).
- For 87.7% of contacts, the caller considered their needs were met and over 80% of callers managed through de-escalation or navigation during the call (see Figure 14).
- 13.4% of contacts are identified as needing follow-up, with less than 2% referred to emergency services and less than 5% referred to the SA mental health triage helpline.
- 25% of contacts recorded suicidal ideation as a factor.
- 3% of contacts reported they would have attended hospital or called an ambulance if they had not used LETSS (see Figure 15). This represents about 10 callers per month.

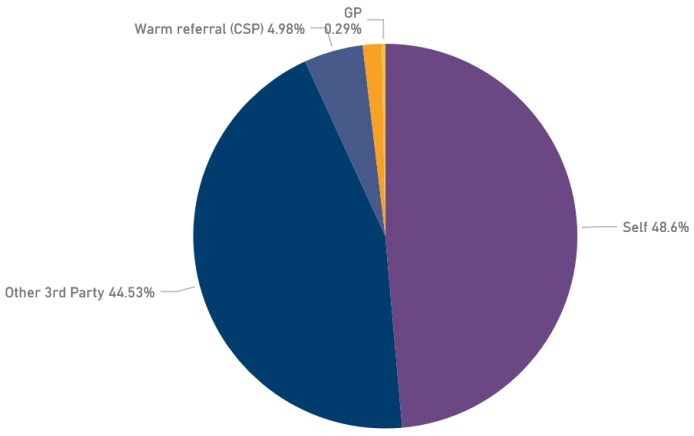

Figure 13 – Referral to LETSS

Source: Unpublished data from the POWER-BI dashboard provided by the Adelaide PHN.

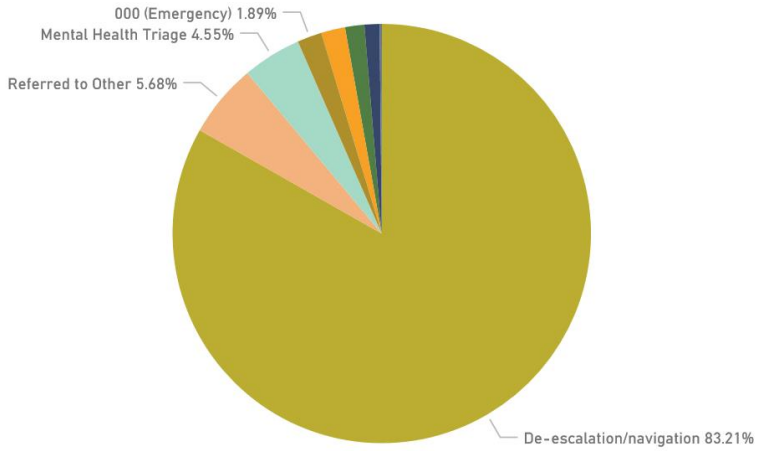

Figure 14 – Referral from LETSS

Source: Unpublished data from the POWER-BI dashboard provided by the Adelaide PHN.

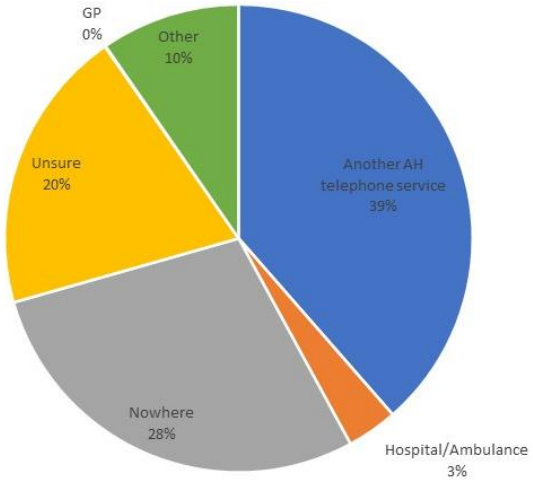

Figure 15 – Support that would have been accessed if not for LETSS

Source: Unpublished data from the POWER-BI dashboard provided by the Adelaide PHN.

Improving the program

The following potential opportunities to improve the LETSS were identified from the surveys and interviews with the service provider and key stakeholders:

- **Extend the service to provide in-hours support** and to 1-2 am after hours. The service is funded only for the social after-hours support period. This does not allow sufficient resources in hours to:
- fully develop relationships with the network of potential referrers to LETSS
- follow up with callers and provide ongoing support with service access
- further promote the service to the general public
- effectively engage more vulnerable communities.

  Similar service needs exist during the in-hours period. It is considered an extension of the service would also allow continuity of access to people with mental health needs and improve health literacy.

- **Effective measurement of outcomes or impact** would provide a more robust basis for assessing the effectiveness of the service. LETSS has commenced planning and investing in how the quality, outcomes and value of the service might be measured in the future.

- **Funding to meet unmet demand and actual service costs**. The service reports that it is currently operating at capacity, but with additional funding could provide more services both after hours and in hours. The workforce is available to provide service expansion.
- **Partnership development with Country SA PHN** with a view for further service expansion.

Stakeholders consulted and survey responses

Key stakeholders consulted during the case study included the Mental Health Coalition (involved in the design of the service), PHN (funding the service), Skylight (providing the service on behalf of the consortium), SA Police and Central Adelaide LHN (referral of clients to the service). The number and nature of individuals interviewed from stakeholder organisations is provided in Table 26.

Table 26 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other
Skylight, LETSS		3	
Adelaide PHN	2		
Central Adelaide LHN Coordinator			1
Mental Health Coalition			1
SA Police			1
Sonder Walk-in Clinic			1
Total	**2**	**3**	**4**

Table 27 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider survey (case study providers)	1
Commissioned service provider survey (other commissioned providers)	2

7 Hunter New England and Central Coast PHN

Case study scope and focus

The Hunter New England and Central Coast (HNECC) PHN case study was **program-based** and focused on the **GP Access After Hours Program** also known as the GP After Hours Program – Hunter.

What were the key observations from this case study?

What we learnt:

- GP Access enjoys **a high degree of trust and support** from other providers and the broader community, with key stakeholders emphasising the strong collaboration and collegiality that exists.
- GP Access has strong **collaboration with GPs and other local providers** with participation from over 200 local GPs in the Lower Hunter region to provide the triage, tele-GP and after-hours clinics.
- GP Access is a **well-integrated** system of services providing local telephone triage and linking to tele-GP advice, co-located after-hours GP clinics, home visits and aged care providers.
- Potential exists to **expand the triage service, tele-GP and provider supports** across the PHN and linking these functions to existing after-hours clinics, home-visit services and hospital care in place locally.
- Scope exists for **further integration of GP Access and EDs**. There is potential to explore shared triage models**,** including greater promotion of GP Access telephone triage and the use of GP-led triage for all walk-in patients before attending ED.
- In discussion with patient and community representatives, there were indications that there is **confusion over the various telephone numbers for services that exist**, particularly around Healthdirect and GP Access (given the change in arrangements), but also with the recent emergence of new call-based service providers.
- The ability to actively promote the use of GP Access to the public is limited, in line with restrictions on all medical deputising services. Support is needed to help PHN **identify opportunities to increase public awareness of GP Access triage functions without fuelling unnecessary after hours care.** This could be done in conjunction with Healthdirect.
- The GP Access service is funded from a variety of sources, namely MBS reimbursement, NSW Health, out-of-pocket payments as well as the PHN After Hours Program. The PHN receives significant additional funding through the PHN After Hours Program to support the service contributing over half of the costs.

Locality overview

The HNECC PHN region is the second-largest PHN in NSW and encompasses an area of 133,812 square km and is home to 1.2 million people. The region covers 23 LGAs. The Modified Monash Model classifies a large proportion of the PHN region under the category level 5 of remoteness. The PHN consists of three main areas: The Hunter, Central Coast and New England regions (Hunter New England and Central Coast PHN, 2018a).

The area has a higher proportion of the population that is aged 65 or older at 19.1% compared to the national average of 15.2%. The region has a higher proportion of Aboriginal & Torres Strait Islander people at 5.4% compared to the national average of 2.8%. Though the region has a lower degree of residents reporting financial stress, the area has a higher proportion of aged residents on pensions and single-parent homes. Due to the largely rural and remote nature of the area, some residents have limited access to internet and transport, which has a negative impact on access to health services, particularly during the after-hours period. The region also grapples with higher than national average rates of alcohol consumption, smoking, obesity, chronic obstructive pulmonary disease, circulatory system disease and musculoskeletal system disease (Hunter New England and Central Coast PHN, 2018a, 2018b).

Figure 16 shows a map of the entire HNECC PHN region.

Figure 16 – Map of the HNECC PHN

Source: Department of Health (2015)

In comparison to the 31 PHNs in Australia (Australian Bureau of Statistics, 2016a), the HNECC PHN is ranked:

- **5th** in terms of the total population
- **6th** in term of the proportion of the population aged 65 years or older
- **6th** in terms of Aboriginal and Torres Strait Islander peoples supported.

Figure 17 presents data indicating that relative to other PHNs, usage of GP care in the after-hours period is lower and use of ED for low-urgency issues is higher than the national average. In particular:

- GP after-hours services per 1,000 residents was **300**, less than the national average of **490**. The HNECC PHN is ranked **20th** highest of all 31 PHNs on this measure.
- After-hours low-urgency ED attendances per 1,000 residents was **92**, more than the national average of **56**. The HNECC PHN is ranked **25th** lowest of all 31 PHNs on this measure.

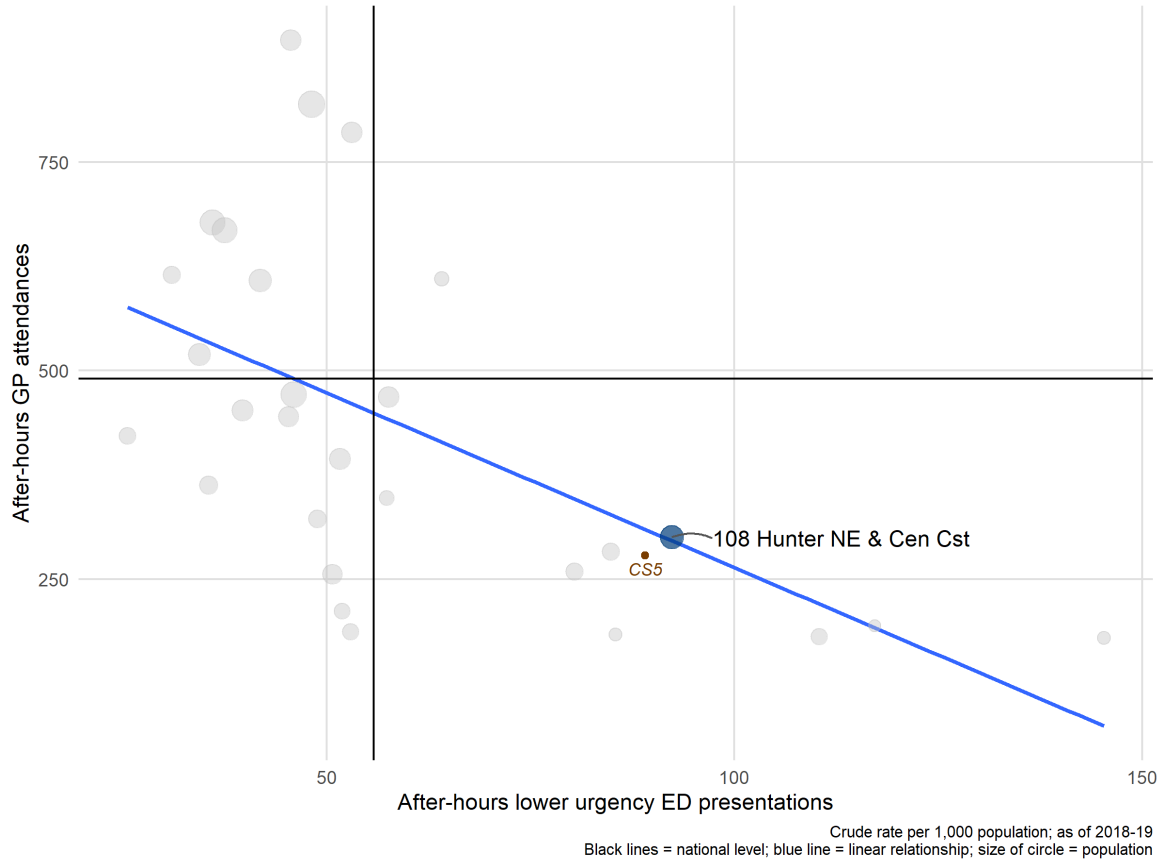

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Figure 17 – GP after-hours services vs after-hours low-urgency ED attendances, 2018–19

Sources: ED – Australian Institute of Health and Welfare (2020b); GP AH – Australian Institute of Health and Welfare (2020a)

The PHN has a significant rural population, particularly in the New England area, with GP visiting medical officers (VMOs) servicing the local hospital in smaller regional communities. This may contribute to more after-hours primary care being recorded in EDs. The case study area of Hunter (shown as CS5 in Figure 17) has slightly lower rates of after-hours GP attendances and ED presentations than for the HNECC PHN as a whole.

Total annual funding for the After Hours Program for the past two financial years is presented in Table 28. This indicates that HNECC receives a greater share of after-hours funding on a population basis than most PHNs.

Table 28 – Summary of HNECC PHN After hours funding

Financial year	Total After Hours allocated program funding (PHN)	After Hours funding per 1,000 population (PHN)	All PHN After Hours Program funding	PHN ranking

			per 1,000 population	(After Hours funding per 1,000 population)
2019–20	$5,488,245	$4,532	$3,056	10th
2018–19	$5,088,245	$4,201	$2,867	9th

Health services within the HNECC PHN area

The PHN covers two of the NSW local health districts. Table 29 summarises the services operating in the HNECC PHN region.

Table 29 – Services in the PHN

Type	Number
GPs	1250
GP practices	410
Aboriginal Medical Services	9
Pharmacies	303
Public hospitals	31
Hospitals that provide multi-purpose health services	10

Sources: Hunter New England and Central Coast PHN (2018b); Hunter New England and Central Coast PHN (2018c); NSW Government (2015)

Hunter New England and Central Coast PHN approach

In 2015, the New England, Hunter and Central Coast Medicare Locals were replaced by the HNECC PHN. In the transition, the PHN continued funding the operations of certain after-hours services. Due to the expansive and diverse nature of the regions within the PHN, its approach to increasing access to after-hours services has been to provide separate after-hours models targeting the three regions: Central Coast, Hunter and New England. Though after-hours approaches have been predominantly targeted by a region-based approach, there are projects that operate across both of the Hunter and New England regions, such as the Aged Care Emergency (ACE) program.

Since the establishment of the PHN in 2015, the organisation has conducted several evaluations of their funded after-hours programs, including external evaluations of the ACE and GP Access programs. In 2018, the HNECC PHN, in conjunction with HealthWISE, completed a clinical redesign of the Small Town After Hours program to ensure the program was still meeting the needs of residents throughout the New England region. New England North West Health Ltd. (HealthWISE) is a not-for-profit organisation that provides primary care services across the New England North West region of the PHN. HealthWISE also provides services to the Darling Downs West Moreton and Goondiwindi areas of Queensland (HealthWISE, 2020). The Small Town After Hours program has been running for more than 10 years and was originally established by the Division of General Practice.

In addition, the HNECC PHN has performed national and international reviews of best practice models for after-hours care and frequently sought input and feedback from key stakeholders through surveys, quarterly service provider meetings and the collection of patient-reported experience measures (PREM) data.

Funding

The PHN has been relatively well-funded through the After Hours Program compared with other PHNs. Along with Tasmania PHN, it has been provided with additional funding above the level that would be indicated through the funding formula to provide support for the GP Access. The service is jointly funded through the PHN and local area health network. The case study considered: how the service was operating, what it has been able to achieve and the extent to which it appeared to be meeting local needs. It was not able to assess to what extent this additional funding is justified relative to other initiatives and whether the balance of funding between the levels of government and private expenditures is appropriate. This equity issue is examined in more detail in Chapter 8 of the main report.

Needs assessment process

HNECC PHN's after-hours needs assessment and after-hours program evaluations were incorporated into the PHN's core needs assessment alongside other regional health priorities. The PHN was undertaking a comprehensive after-hours needs assessment that was expected to continue until August 2020. The aim of the needs assessment is to inform service redesign and evaluate existing contracts that are in effect until June 2021. The PHN has also engaged in multiple activities to identify other gaps in after-hours services. These activities included:

- after-hours service mapping
- qualitative analysis of population health need
- jurisdiction scan and literature review on the drivers of health usage
- assessment of after-hours usage compared to unmet demand
- monitoring and collection of patient experience measures
- conducting patient feedback surveys
- monitoring and analysing category 4 and 5 ED presentations
- hosting stakeholder consultations that include input from GPs, practices, the LHDs, service providers, RACFs and Aboriginal & Torres Strait Islanders.

The PHN cited several data sources that informed their needs assessment process. These included:

- Practice Incentive Program (PIP) data
- MBS claims related to after-hours items
- demographic data
- data acquired from MDS services operating within the PHN region
- data acquired from after-hours telephone services
- ED attendances
- National Health Service Directory data, which the PHN collected and verified.

The HNECC PHN needs assessment identified the following regional after-hours challenges/priorities:

- limited access to after-hours GPs
- limited access to after-hours services for older residents
- limited access to after-hours services for residents living in rural and remote areas
- areas of primary care workforce vulnerability
- lack of health service integration, coordination and information sharing.

Though HNECC PHN feels they already perform very comprehensive needs assessments, they hope to include more continuous data sources and enhance their data collection process in the future. The PHN noted the current limitations they have in analysing their data, including limited granularity of data sources, contemporaneousness of data and the general lack of reliability of the National Health Service Directory.

Healthdirect maintains the National Health Service Directory, a core resource for providing callers with clear advice regarding after-hours services. The concerns over reliability of the information were shared by other PHNs and Healthdirect. Perhaps there is scope for PHNs to

play a stronger role in helping keep the directory up-to-date, including information on general practices and after-hours GP services. They could perhaps incentivise providers to maintain up-to-date profiles with the required information.

Central Coast region

The Central Coast has a population of 327,736 residents (Australian Bureau of Statistics, 2016c). As of 2018, there is one LGA in the Central Coast. The median age in the region is 42 and the area has a higher proportion of individuals aged 65 or older at 20.9% of residents versus 15.9% nationally. Aboriginal & Torres Strait Islanders make up 3.8% of the population. The Socio-Economic Indexes for Areas (SEIFA) score in the region is 989 (1000 national average) and the unemployment rate is higher at 6.5% compared to the NSW average of 4.8% (Australian Bureau of Statistics, 2019). Compared to NSW as a whole, the region has higher rates of smoking, alcohol consumption, and obesity. Central Coast also has a higher proportion of individuals who report significant or very significant rates of psychological distress, residents with diagnosed mental health and behavioural conditions, and hospitalisations due to self-harm. While diabetes rates are lower than the NSW average, Central Coast has marginally higher rates of high cholesterol, arthritis, asthma and chronic obstructive pulmonary disease among its residents. The region also has a significantly higher rate of potentially preventable hospitalisations at 2,272 per 100,000 people compared with 2,104 per 100,000 for the NSW population generally. A higher proportion of residents in the Central Coast region report issues such as cost, transport and internet access as obstacles to accessing care, with 3% in Central Coast vs 2.5% NSW average (Hunter New England and Central Coast PHN, 2018c).

The HNECC PHN provides funding to the GP After Hours Program – Central Coast, which includes two sites called the Bridges After Hours GP Clinics and the Woy Woy After Hours Medical Service. Central Coast Primary Care operates the services and receives support from both the PHN and the Central Coast LHD. There are two after-hours clinics in Erina and Kanwal that are listed on the Bridges website. Central Coast Primary Care is funded to also provide and manage the Woy Woy After Hours Medical Service.

Bridges After Hours Erina and Kanwal clinics operate from 7:00 pm to 10:30 pm on weekdays, 3:00 pm to 10:30 pm on Saturdays, and on Sundays and public holidays from 10:00 am to 7:00 pm at the Erina clinic and 1:00 pm to 6:00 pm at the Kanwal clinic. The Woy Woy clinic is fully bulk billed and located at the Woy Woy Rehabilitation Hospital. It operates from 6:00 am to 11:00 pm on weekdays, 12:30 pm to 11:00 pm on Saturdays and 8:00 am to 11:00 pm on Sundays.

In the event that a Central Coast resident needs after-hours support beyond the services' hours of operation, Central Coast Primary Care established a partnership with GP Access. Residents who contact the service via phone outside their service hours will be diverted to the GP Access call centre for triage.

Table 30 shows the standard consultation fees, which vary by site (Central Coast Primary Care, 2020).

Table 30 – Kanwal and Erina after hours clinic information

Kanwal AH Bridges Clinic		Erina AH Bridges Clinic	
Consultation fee	**Cost ($)**	**Consultation fee**	**$ Cost**
Standard rate:	$68	6-7 pm weeknights:	$70
Note: Children, Health Care Card Holders and pensioners are bulk billed		From 7 pm weeknights	$80
		Weekends:	$80
		Note: bulk billing at GP's discretion.	

Hunter region – GP Access

According to the 2016 census, the Hunter region has a population of approximately 700,000 residents and consists of 10 LGAs (Australian Bureau of Statistics, 2016a; Hunter New England and Central Coast PHN, 2018a; Regional Development Australia, n.d.). Major urban areas in the region include Newcastle, Maitland, Lake Macquarie and Cessnock (Regional Development Australia, n.d.). Various areas in the Hunter are experiencing high annual population growth. Maitland is experiencing the highest annual population growth throughout the PHN at 1.5%, followed by Port Stephens at 1.1%, Cessnock at 1% and Newcastle at 0.8%. Several LGAs in the Hunter have a high percentage of residents aged 65 or over. For example, 30.1% of residents in the Mid Coast LGA are aged 65 or older. Despite higher-than-average SEIFA scores compared to the entire HNECC PHN region, Hunter region scores are still lower than the national average. Newcastle reported the highest SEIFA score of 997 and Cessnock the lowest at 925 compared to the national average score of 1000. In comparison to NSW, the Hunter region also grapples with higher-than-average rates of smoking, obesity and risky alcohol consumption. The region also has a higher prevalence of chronic conditions such as asthma, hypertensive disease, chronic obstructive pulmonary disease and arthritis (Hunter New England and Central Coast PHN, 2018a).

The main after-hours program that services the Hunter region (the Lower Hunter, Lake Macquarie, Newcastle and Maitland subregions), is the GP After Hours Program – Hunter, or GP Access. The GP Access program provides after-hours primary care support via a call centre and five after-hours clinics situated throughout the Hunter region. The GP Access program is the focus of the case study and will be discussed further in the GP Access program section below.

In addition to GP Access, the HNECC PHN also supports the Aged Care Emergency service, which provides both in-hours and after-hours support to RACFs operating in both the Hunter and New England regions. The service treats residents of aged care facilities who are experiencing non-life threatening conditions within their facilities. The service also provides guidelines for aged care staff about how to effectively decide when a GP is needed and supports aged care workers through a 24-hour nurse-led telephone service. The Aged Care Emergency service is jointly funded by the Hunter New England LHD and support is provided by the GP Access program during the after-hours period. During normal business hours, the call service is operated by the Hunter New England LHD.

New England region

The New England region consists of 12 LGAs and has a population of 154,184 residents (Australian Bureau of Statistics, 2016e). Urban areas in the region include Tamworth and Armidale in which about 46% of the total population resides (NSW Parliament, 2014). The region contains a high proportion of Aboriginal and Torres Strait Islander people with this population group making up 21.6% of residents in Moree Plains, 12.8% in Gunnedah, 12.4% in Liverpool Plains, and 10.1% in the Tamworth area. Certain LGAs within New England have a high percentage of people aged 65 or over with 27.5% of residents in Tenterfield aged 65+, 26% in Gwydir and Walcha, and 25.9% in Glen Innes Severn. As shown in Figure 18, many of

the New England LGAs have a relatively low SEIFA score, therefore, residents experience a higher degree of socio-economic disadvantage compared to residents in other areas of the HNECC PHN, such as Hunter or the Central Coast.

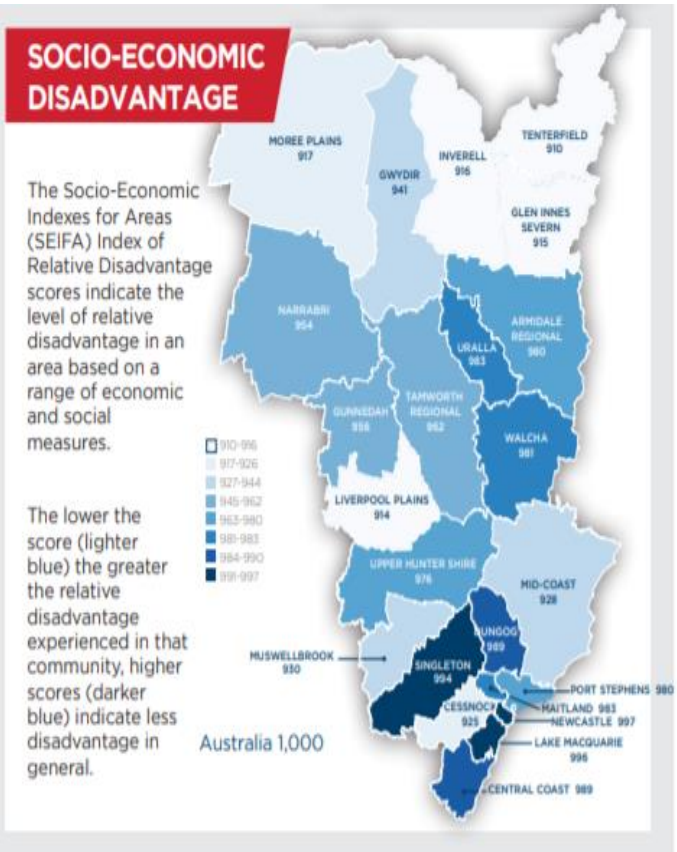

Figure 18 – Level of socio-economic disadvantage

Much of New England consists of rural and remote areas, and the region struggles with general access issues and internet and transport availability. LGAs in the region also report higher rates of unemployment, single-parent homes, smoking, physical inactivity, chronic disease, obesity and alcohol consumption (Hunter New England and Central Coast PHN, 2018a).

The New England Division of General Practice (as it was at the time), in conjunction with HealthWISE, which still coordinates the program, established the Small Town After Hours program. The program aimed to increase residents' access to after-hours primary care services and reduce pressure on GPs across the rural and remote towns in the New England region.

The Small Town After Hours program provides a telephone link between registered nurses in a rural and remote hospitals with GP VMO from larger hospitals where the hospital GP is unavailable. It deals with triage category 3–5 patients presenting at local hospitals, preventing them from needing transport to a larger district hospital. The program covers after-hours care, but also provides holiday and sick cover for local GPs. HNECC PHN continues to fund the program, which is operated by HealthWISE. The program provides services in 9 towns across New England including:

- Barraba
- Boggabri
- Manilla
- Walcha
- Wee Waa
- Bingara
- Emmaville
- Murrurundi
- Warialda

The Small Town After Hours program has eight community doctors on a roster providing video and telehealth after-hours services. The program aims to treat triage category 3–5 patients in the local hospital, with triage category 1 and 2 presentations transferred to larger regional hospitals, such as Armidale and Tamworth Hospital.

Along with the Small Town After Hours program, RACFs in the New England region are also able to receive support and services through the Aged Care Emergency service.

Sourced from the HNECC PHN Activity Work Plan, the PHN's After Hours Program funding allocation is presented in Table 31.

Table 31– PHN After Hours activities and funding allocation

Priority area	Planned expenditure, 2019–20		Represented in case study[1]
	$'m	%	
Small Town After Hours	$0.05	1	
Aged Care Emergency Program	$0.37	8	✓
GP After Hours Program – Hunter[1]	$4.06	82	✓
GP After Hours Program – Central Coast	$0.40	8	
After-hours primary health care planning	$0.06	1	
TOTAL	**$4,939,420**[2]	**100%**	

[1] *Due to representation of the GP After Hours Program and our focus on the Hunter region, this case study will briefly cover the Aged Care Emergency Program and its impact on the region.* [2] *Includes only the amount planned for each activity, and disregards funding allocated for administrative and staffing expenses.*

Source: Hunter New England and Central Coast Primary Health Network (2019).

Service design

The GP Access Program is a jointly funded initiative by the Hunter New England LHD and the HNECC PHN. The service is run by Hunter Primary Care, formerly the Hunter Division of General Practice, then Hunter Medicare Local and then Hunter Primary Care with the establishment of PHNs in 2015 (Hunter Primary Care, 2020a).

GP Access includes five after-hours clinics across the Hunter region, and a call centre that triages patients, books after-hours appointments, and can also arrange home visits and transport where required. The program qualifies as a medical deputising service and bulk bills through Medicare. The bulk of patients are booked through the call centre, although some are diverted to the service from the ED, and all are triaged prior to an appointment being made. GP Access had 240 GPs on the roster providing after-hours coverage for the program.

More than half of the HNECC PHN's population resides in the Hunter region, and given that volume of patients and its impact, Hunter Primary Care considers that the level of funding remains justified. The PHN has had a higher level of funding made available through the After Hours Program relative to the population served. Table 32 lists the GP Access clinic locations throughout the Hunter region (Hunter Primary Care, 2020b).

Table 32 – GP Access clinic locations

Clinic location	Co-located with hospital
Belmont Hospital Clinic	✓
Calvary Mater Newcastle	✓
John Hunter Hospital Clinic	✓
Maitland Hospital Clinic	✓
Westlakes Community Health Centre (Toronto Polyclinic)	

Program origins – GP Access

The GP Access Program was established in the late 1990s. Due to limited incentive for health professionals to provide after-hours services and increased emphasis on achieving work/life balance, interviewees reported that many individuals felt GPs and other health providers across Australia were less inclined to work during the after-hours period. As a result of this shift and the growing need for after-hours services in the region, the Hunter Urban Division of General Practice produced a report on after-hours care in 1996 that yielded several recommendations on the future of after-hours service delivery in the region. The report was a collaborative effort that included consultations with GPs, community members and representatives across the Hunter and produced the following recommendations:

- Further examine the existing after-hours needs and foster the development of new facilities to provide after-hours care. In particular, the establishment of both co-located and community venues could prove invaluable in improving access to after-hours care in underserviced areas or reduce the burden on community EDs.
- Examine the potential for the development of a telephone triage service.
- Explore other potential initiatives and projects that could help improve access to after-hours services and promote continuity of care.
- Conduct community and provider surveys with the purpose of garnering feedback on these proposed after-hours projects.
- Discuss and explore funding mechanisms for the initiatives and develop funding applications where necessary (Foster et al., 1996).

As a result of these findings and an understanding among community GPs and organisations that there were existing gaps in after-hours care throughout the region, the GP Access Program officially began operations in 1999 in the Maitland region. The program expanded to five GP Access clinics. GP Access pre-dates the national Healthdirect service and its premise was to provide accessible and affordable care that is predominantly delivered through the call centre and the five GP Access clinics. The call centre is led by nurses who are backed up by GPs on call.

In contrast to 13SICK and other MDS services, a stakeholder stated that the GP Access program is focused on managing rather than creating demand. This is due to the provision of block funding, which means the service is not incentivised to provide costly home visits or rely solely on the generation of MBS revenue. Another contributing factor is that the participating GPs also work during the day and are not competing with daytime GPs – they understand what should be treated during the day versus what requires medical attention after hours, and they triage accordingly.

Several stakeholders stated that collegiality is an integral part of the GP Access model. Due to the medical workforce shortage in the region, there is limited competition among GPs and they are often overstretched. Therefore, GPs were able to work together to fill the gap that exists in after-hours care. Another important component of the program is the local knowledge and presence of the GP Access team. All of the GPs and nurses who work for GP Access also work in community EDs, health organisations and general practices throughout the Hunter region. They understand residents' way of life and have knowledge of existing services that are accessible to these patients.

A similar triage program is funded by Primary Health Tasmania. This program is call GP Assist and also has long-standing support in the community from both providers and patients. Table 33 compares features of the programs.

Table 33 – Comparison of GP Access (HNECC PHN) and GP Assist (Primary Health Tasmania)

Feature	GP Access	GP Assist
Ownership	Hunter Primary Care, a company limited by guarantee	Privately owned entity

Feature	GP Access	GP Assist
Linkage with Healthdirect	No formal arrangement exists	Only calls triaged with ED disposition or see GP within 12 hours are diverted to GP Assist call centre
Funding of call centre	PHN funds nurse and GP on call for GP Access call centre	Tasmanian Department of Health funds nurse and PHN funds GP on call and majority of the operating costs for GP Assist call centre
Ambulance triage of calls	GP Access does not provide secondary triage service for NSW Ambulance. Healthdirect provides this for NSW.	GP Assist does not provide secondary triage service for Ambulance Tasmania
Geographical coverage	Only the Lower Hunter sub-region of the PHN, albeit the most populous	Whole of PHN
Use of service by rural GPs	Rural GPs in other subregions rely on GP visiting medical officer arrangements and regional hospital support	Strong GP Assist focus on supporting rural GPs by providing telephone-based deputising service for participating rural GPs
Residential aged care facilities support	Focus on supporting residential aged care facilities via integrated program of training and protocols under the Aged Care Emergency service	Support is provided to residential aged care facilities by GP Assist
Staffing	Cooperative roster of local GPs run 5 integrated and co-located after-hours clinics	Relies on privately owned after-hours clinics in urban centres – Hobart and Launceston
Bulk-billing GP clinics?	Yes	Privately owned after-hours clinics – not 100% bulk billing
Appointment booking?	GP Access makes direct booking with clinics for direct and ambulance calls	GP Assist refers callers to available clinics to make their own appointments
Linkage with ED	Well-integrated system of referral between public ED and GP Access clinics.	EDs are not integrated with GP Assist or with local after-hours GP clinics
Support to other health professionals	GP Access provides support to residential aged care facilities but not to other services	GP Assist provides separate telephone advice to other health professionals and services (about 25% of calls)

GP Access program challenges

The service regards the direct marketing restrictions have reduced its ability to actively market and raise awareness of after-hours services.

GP Access is a recognised medical deputising service with a focus on managing demand for after-hours use of primary care services in instances of urgent need. The service is listed on the Healthdirect website but there are no other direct links. Several MDSs have recently commenced operations in the region focused on generating demand and improving income streams through the provision of high-volume bulk-billed home visiting services. These businesses have been promoting their services heavily throughout the region, creating significant growth in service provision.

Since 2018 when the restrictions on direct marketing were introduced, GP Access has not been able to advertise or promote awareness of its services as it did previously. While this has dampened direct promotion of after-hours service use, it has also reduced the ability for GP Access to promote the use of their telephone triage service to the public. GP practices that use GP Access as their deputising service and participate in the roster for GP Access can still provide information about the service and link callers to the Healthdirect and GP Access after-hours line.

The current situation has generated a level of policy dissonance at local level, where on the one hand the service and the PHN aim is to restrict after-hours care to urgent cases, while on the other seeking to improve access/availability of after-hours care. Improving the latter make the former less likely. There may be scope for the PHN to work closely with GPs, other service providers (such as pharmacies) and GP Access to find ways to promote the appropriate use of services.

Efforts to effectively manage demand for after-hours services do not necessarily translate into system savings, making it hard for GP Access to demonstrate value for money

Recent studies of the impact of GP Access have sought to assess the costs and effect of the service on after-hours service demand, including ED attendances, home visits and GP clinic presentations. While these studies have demonstrated the potential costs of the services avoided far outweigh the costs of providing them (previously estimated at $10.5m a year), the demand for these services (particularly ED services) often remains greater than service capacity, resulting in extended waiting times. Excess demand and extended wait times makes it hard for GP Assist to demonstrate the dollar value to hospitals, meaning the benefits accrued from the service are not being fully appreciated.

While the introduction of new telehealth MBS items during the COVID-19 crisis had created new service opportunities, it caused uncertainty for the business model of GP Access

GP Access receives funding from the PHN to provide free access to a telephone-based nurse triage service, with back-up advice from an on-call doctor, and the operation of four bulk-billing, hospital co-located after-hours clinics. The introduction of MBS items for telehealth during COVID-19 has changed the service landscape. Clinic and home-based care is now being substituted to an extent with telehealth and videoconferencing service offerings emerging from existing GP practices and alternative providers.

Uncertainty over the long-term maintenance of these new item numbers has created challenges – and maybe new opportunities – for the planning and evolution of the GP Access business model.

Perceptions that the Program funding streams were largely flat and the cost of business was rising

Though Hunter Primary Care feels that GP Access has achieved a high level of patient awareness, there were concerns that the level of funding had not kept up with costs. The service expressed the view that there is a growing disparity between funding and costs has placed pressure on GP Access to consider out-of-pocket charges to patients. The case study has not examined in detail whether these claims are justified.

There was a general lack of transparency and clarity among governing bodies and service providers around the intended program objectives

The LHD would like GP Access to rapidly treat more category 4 or 5 ED patients to help reduce demand on local hospital EDs. In addition, they would like to shift funding away from the nurse-led call centre, which they feel is a service that Healthdirect could provide and allocate additional funding to direct patient care. Hunter Primary Care is focused on providing quality care after hours through a demand management model, which includes pre-booking appointments. Hunter Primary Care also stresses the importance of their call centre, which they feel is integral to triaging patients and integrating existing health services.

Health literacy in the community was an issue

GP Access feels that the LHD advocating for rapid ED diversion and treatment of patients at GP Access clinics sends the wrong message to the community. This type of method may

encourage 24/7 access to care, rather than a system that seeks to guide people to appropriate care both in terms of place and time. In addition, there has been the emergence of after-hours bulk-billed services that provide non-urgent care that should be treated during the day. GP Access feel that these services, coupled with certain LHD objectives, promotes increased usage of the ED and encourages people to seek after-hours treatment out of convenience, not necessity. This is an ongoing tension that exists across Australia, especially in urban areas, which raises the question: are these types of programs focused on delivering a demand management model to reduce after-hours activity or are they focused on improving access and convenience to after-hours services?

Stakeholders also felt that there was an expectation among some consumers that medical resources were unlimited, even during the after-hours period. For this reason, they advocate for increased emphasis on consumer health literacy.

What impact has the program had?

Patient volume and generated cost savings

HPA did not have access to detailed costing analysis and funding information. It was advised that the operating costs of GP Access (triage and clinics) amounted to around $7m each year, comprising:

- Triage – covering after-hours periods 365 days a year; the triage function is staffed by a duty manager and a combination of administration staff and registered nurses.
    - Total annual cost approximately: $1.2m
- Clinical Services – provided through a combination of:
- GPs in each of the five clinics for the after-hours period plus overnight on-call. Total annual cost approximately: $2.6m
- Nursing and administration staff in the clinics over the same operating hours. Total annual cost approximately: $1.6m
- Clinical Directorate – covers pathology and imaging result checking, incident management and clinical governance oversight.
    - Total annual cost approximately: $0.2m
- Head office management – consumables and operating costs and overheads
    - Total annual cost approximately: $1.7m

The PHN's Activity Work Plan for 2019–21 specified that approximately $4.1m will be allocated from the PHN after-hours primary care program, with $0.6m provided from other sources. The specific contributions to the overall operating costs from MBS receipts, out-of-pocket payments by patients and LHD funding were not specified.

The PHN has a relatively high level of low- urgency ED attendances. The reasons for this are complex and will, in part, reflect historic patterns of service use. The key question in assessing the effectiveness of the Program is what the rates would be in the absence of the service.

In recent years, Hunter Primary Care and external organisations have produced reports on GP Access in order to explore the program's value for money. In 2015, the Hunter Research Foundation produced 'A Cost Study of GP Access After Hours (GPAAH)' (Hunter Research Foundation, 2015). The report sought to analyse the potential financial impact and cost savings that GP Access had generated for the region. The organisation used patient data from the 2013–14 financial year. Though the annual program cost for 2013–14 was approximately $7.6m, the report estimated that without GP Access operating in the region providing after-hours care to residents would have cost the health system $18.1m, therefore, they estimated that GP Access saved the health system around $10.5m (see Table 34).

Table 34 – Net cost estimates based on different ED marginal costs

Type of cost	ED marginal cost scenarios:		
	Low ED cost	NSW ED cost	Baseline
ED marginal cost	$321.80	$587.01	$402.26
ED marginal cost: deviation from baseline	-20%	26%	–
Net cost	-$7,225,633	-$18,158,859	-$10,542,398

Source: Hunter Research Foundation (2015)

The report acknowledged that the findings were heavily dependent on the marginal costs estimates for ED services and the anticipated use of ED services in the absence of GP Access (see Table 35), given the sensitivity of the results to changes in these variables. The sensitivity analysis undertaken generated a range of estimated net costs from $18.2m (saving) to $0.5m (loss).

Table 35 – Net cost estimates based on different ED utilisation rates

	ED presentation rates			
	50%	40%	30%	20%
Net cost	-$7,767,681	-$4,872,325	-$2,279,610	$513,445

Note: Baseline cost savings of $10.5m used in the report assume 61% ED presentation rates.

Source: Hunter Research Foundation (2015)

It is not clear to what extent the following costs were included in the analysis of GP Access:

- Recurrent costs associated with providing pathology and imaging tests and pharmaceutical supplies.
- Capital costs of the GP Access clinics co-located on hospital sites.
- Capital and recurrent costs of Healthdirect in supporting GP Access triage functions.

Even though this report provided a comprehensive overview of the potential savings the program had generated for the health system, these savings may not have directly translated into savings for the hospital system. There was clearly a saving to hospitals if the total number of ED attendances fell. However, this saving was at the margin unless there was a stepped change reduction that led to a reduction in staff numbers in the ED (Blue Moon Research & Planning Pty Ltd, 2002).

In line with the Hunter Research Foundation's findings, Hunter Primary Care used several patient measures covering the period of service operation from June 2017 to June 2018 (see Table 36). The measures used included estimates of ED presentations avoided and the proportion of patients with less than a 30-minute wait time. These data relate to 2017-18. The table includes some additional and more recent measures derived from the PHN survey which indicate the volumes of patients accessing the service.

Table 36 – GP Access patient measures 2019–20

Measure	Number	Year
Number of patients managed by GP Access call centre	74,069	2019–20
Number of patient attendances to GP Access after-hours clinics	56,110	2019–20
Number of ED presentations avoided due to GP Access	51,173	2017–18
Number of patients referred from ED to GP Access clinics	12,822	2019–20
Number after-hours service avoided (i.e. callers to seek care with usual GP)	2,274[1]	2019–20
Percentage of patients with less than 30-minute wait time	93%	2017–18
Number of patients identifying as Aboriginal or Torres Strait Islander	9,738	2019–20

Measure	Number	Year
Number of after-hours ambulance calls redirected to GP Access clinics	197	2019–20

Represents figures for FY 2019–20 July-March only.
Sources: ED presentations avoided and wait times data (Hunter Primary Care, 2018); all other measures: HPA PHN Survey;

The GP Access call centre manages over 70,000 calls a year and the fixed and variable costs of the centre are about $1.4 million a year, which indicates that the average cost of managing a call was less than $20.

Hunter Primary Care and participating providers stated that COVID-19 has had a major impact on service operations. Beyond reducing staff hours due to decreased patient demand, the GP Access team has had to implement a wide range of clinical support at the clinics to accommodate the shifting nature of service delivery during this period. In addition to COVID-related pressures, the service continued to grapple with what they claim as the increasing cost of business and relatively flat funding from the PHN, LHD and Medicare.

Though COVID-19 has decreased the number of patients accessing the service, the GP Access call centre has had historically high demand with an estimated 200–300 calls abandoned each night in February 2019 due to service demand that they could not meet.

Hunter Primary Care and the team stressed the importance of operating a demand management model that provides appropriate high-quality care during the after-hours period. Due to the finite amount of funding they received, they have limited service capacity. Despite these potential limitations, Hunter Primary Care and other stakeholders say the service is an affordable after-hours option for vulnerable patients and with significant use (17%) by patients identifying as Aboriginal or Torres Strait Islander.

Stakeholder and community perspectives

The service is highly valued by residents, health services and community providers

Beyond the number of patients treated and the amount saved on potentially avoidable ED presentations, stakeholders and providers reflected on the effect the service has had on the serviced areas within the Hunter region. With a roster of 240 GPs, GP Access has been successful in garnering a high degree of engagement and positive reception among community GPs and health providers across the region. There was also a high level of awareness of the service, the call centre and the five GP Access clinics

GP Access was well-integrated with community health providers and organisations

Due to the program's long-standing presence in the region, GP Access has achieved a high level of integration with several community health providers, including the local hospitals, aged care facilities and NSW Ambulance. For example, in the event of a non-urgent ambulance call, NSW Ambulance staff can call the GP Access helpline and book an appointment on behalf of a patient or provide them with the program contact details. The GP Access program has also been able to provide after-hours support through their call centre to RACFs that participate in the Aged Care Emergency service and to the Central Coast's Bridges After Hours Program. The program appears to be well-known among residents and receives an estimated 60,000 to 80,000 calls annually.

One size may not fit all, but increased collaboration and information sharing may benefit the PHN region

Though the service has been beneficial for the areas within the Hunter, there is an understanding among stakeholders that there is no one-size-fits-all solution. The GP Access model may not be appropriate for all regions. The service advocated for expansion of GP Access to Nelson Bay, but local GPs did not support or trust the service given their existing market dynamics. In rural areas, there are potential issues around the GP Access model

reducing GP incomes due to the high VMO rates. For this reason, the HNECC PHN and other stakeholders have needed to explore different options for different regions.

Despite this important reflection, the HNECC PHN region may benefit from increased sharing of information and collaboration across the Hunter, Central Coast and New England regions to tackle issues relating to after-hours service delivery.

Improving the program

Due to the existing program challenges listed above, potential opportunities to improve the GP Access program may exist as follows:

- GP Access is well integrated with ambulance, aged care and acute care sectors. However, there would appear to be room for **further coordination and integration of triage and face-to-face service provision by GP Access and hospital EDs**. For example, exploration of a joint triage function where GP Access callers with an ED disposition can be fast-tracked when presenting to the ED, encouraging uptake of the GP Access triage service and streamlining the hospital management of the patient.
- Conversely, there may be scope for **self-referred patients who walk into the ED to be triaged and booked directly into the GP Access clinics** using a shared booking system. This way joint ED/GP Access clinic capacity planning and management may be improved.
- GP Access is well regarded by local GPs, other service providers, patients and the public. There is scope to further explore the potential to **broaden the application of the GP Access triage function across the Central Coast and New England** by considering the existing service arrangements for GPs in these areas and looking to identify value-adding functions from the GP Access model. This may involve further consideration of the nature of arrangements in place in Tasmania and the support provided by GP Assist to rural practices in that state.
- In discussion with patient and community representatives, there were indications that there is **confusion over the various telephone numbers for services that exist**, particularly around Healthdirect and GP Access (given the change in arrangements), but also with the recent emergence of new call-based service providers. Depending on what current advertising and marketing regulations will allow, a coordinated and sustained public awareness campaign involving ambulance, hospitals, GP Access and Healthdirect to promote a unified and clear message around preferred pathways to appropriate use of after-hours services. This would require careful branding to deliver simple, unambiguous messaging for the public.

- The ability to actively promote the use of GP Access to the public is limited, in line with restrictions on all medical deputising services. Support is needed to help PHN identify opportunities to increase public awareness of GP Access triage functions without fuelling unnecessary after hours care. This could be done in conjunction with Healthdirect.
    - GP Access would like to consider alternative approaches to contributing to meeting the cost of delivering the service, such as **charging a gap fee** for after-hours care. At present, this idea has received resistance from local stakeholders, but there are concerns about the sustainability of the service given the existing funding streams and the cost of delivering the service.
    - There needs to be **increased communication and collaboration among service providers, the PHN and the LHD** about the overall aims and objectives of the GP Access program and other after-hours services.
    - Stakeholders felt that the MBS telehealth item numbers that have been introduced due to COVID-19 have made a positive impact, but that the funding may not be sufficient. Stakeholders felt the **MBS telehealth numbers should stay in place after**

COVID and they should be increased to make this type of service delivery a more viable option, but that there should also be additional revision of these item numbers to eliminate the potential for abuse and ensure good clinical governance.

Stakeholders consulted and survey responses

Table 37 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other
HNECC PHN	2		
HealthWISE		2	
Central Coast Primary Care		1	
Hunter Primary Care		2	
NSW Ambulance			1
Hunter New England LHD			1
Anglican Care			1
Consumers (PHN Community Council)			2
Total	**2**	**5**	**5**

Table 38 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider survey (case study providers)	1
Commissioned service provider survey (other commissioned providers)	2

8 Primary Health Tasmania

Case study scope and focus

The Tasmanian PHN – Primary Health Tasmania (PHT) – covers all of Tasmania. The case study focused on three programs funded by PHT under the After Hours program:

- The state-wide GP Assist service.
- A specialised service supporting people who are homeless or at risk of homelessness in central Hobart.
- A community development project in Brighton (outer northern Hobart).

These three programs account for around 85% of the PHT After Hours funding program budget.

What were the key observations from this case study?

What we learnt:

- There is **no coordinated after-hours primary care plan for Tasmania** and PHT would welcome the opportunity to work with the Tasmanian Department of Health, Ambulance Tasmania and key players to develop and implement a joint plan.
- GP Assist clearly meets a need and the **service is strongly supported** by GP organisations, the Rural Health Workforce Agency, rural GPs and the Tasmanian Department of Health. PHT regards the model delivered by GP Assist as a fundamental pillar supporting and stabilising rural general practice in Tasmania.
- Opportunity exists to **explore greater integration** of telephone triage and telehealth services provided by Healthdirect, the GP Assist service, after-hours GP clinic services, other telehealth services, Ambulance Tasmania secondary triage and ED triage. There are concerns the current arrangements are overly complex and may be generating additional risks for patients and costs in administration and duplication.
- Based on available information, preliminary calculations indicate the average cost per call to the PHT and Tasmanian Department of Health of GP Assist is about $211, excluding the cost of the Healthdirect initial call costs. There would be great value in the Tasmanian Department of Health engaging with PHT to undertake a joint and more comprehensive **cost-effectiveness evaluation** of GP Assist.
- Subject to the outcome of the Commonwealth Department of Health's review of the PHN After Hours Program, and confirmation of longer-term funding, it would be opportune for PHT to undertake a **review of the service** in conjunction with the Tasmanian Department of Health.
- Stakeholders raised **access issues "in hours"** as a contributing factor to after-hours demand, including limited access to bulk-billing general practice, availability of public transport and care coordination and support for people living with chronic or complex conditions.
- The **PHN receives a larger share of the After Hours Program funding** than the amount that would be allocated through the weighted population-based formula. This additional funding reflects historic support of the GP Assist service. As a result, the PHN has the 3rd highest per capita funding under the PHN After Hours Program.

Locality overview

PHT covers the whole of Tasmania, with offices located in Hobart, Launceston and Ulverstone (see Figure 19).

Figure 19 – Map of the Primary Health Tasmania

Source: Department of Health (2015)

Tasmania's population is over half a million people. While the Tasmanian population has been growing about 1% a year, 15 of the 29 Tasmanian LGAs are projected to decline in population over the next 20 years. The majority of the population lives in Hobart and the surrounding region (40%) and the Greater Launceston area (20%. A further 10% live in Burnie and Devonport in the north west. Tasmania has many small rural towns and villages and remote communities (including people living on Flinders and King islands in Bass Strait).

As noted in the PHT's 2019–2022 Needs Assessment Report (Primary Health Tasmania, 2019), Tasmania has an ageing population. The Needs Assessment Report also notes that Tasmania has high levels of chronic conditions, greater socio-economic disadvantage and poorer health outcomes in the rural LGAs.

Discussions with the PHT team, Tasmanian Department of Health and Ambulance Tasmania confirmed issues contributing to after-hours demand and calls to Ambulance Tasmania included:

- out-of-pocket costs and a lack of access to bulk-billing general practices (both in hours and after hours)

- some general practices "closing their books" to new patients
- the need for more coordinated care of people with chronic and complex health conditions
- expansion of Hospital in the Home services
- lack of public transport after hours.

Tasmania has about 165 general practices with approximately 900 GPs, equating to about 600 full-time equivalent. While there is concentration of general practices in the urban areas and larger towns, the Tasmanian Rural Health Workforce Agency advised that no major town is without a GP service. The Hobart and Launceston regions are largely self-sufficient and able to recruit to fill vacancies themselves. In rural Tasmania, there is a turnover requiring a recruitment pipeline of up to 50 GPs, especially in the rural north west. To date, the Agency has been able to work with affected practices to find new GPs, largely overseas-trained doctors. The flow of overseas-trained doctors to fill these gaps may be interrupted by the COVID pandemic.

Tasmania has three major EDs located at Royal Hobart Hospital, Launceston General Hospital and the North West Regional Hospital at Burnie. There are emergency rooms at 5 smaller regional hospitals and two private hospital emergency services.

In comparison to the 31 PHNs in Australia, the Tasmanian PHN is ranked (highest to lowest):

- **22nd** in terms of geographic areas covered
- **22nd** in terms of the total population supported
- **10th** in terms of Aboriginal and Torres Strait Islander peoples supported (Australian Bureau of Statistics, 2016a).

With respect to after-hours access, Figure 20 presents data on GP MBS after-hours item claims and low-urgency (triage category 4 and 5) ED attendances. The MBS claims data does not include rural GP VMO attendances at smaller regional and rural hospitals as these payments are made by the Tasmanian Health Service. PHT is ranked:

- **27th** (of 31) for GP MBS after-hours services at **187** per 1000 residents (national average of **490**).
- **17th** (of 31) for after-hours low-urgency ED attendances with **53** per 1000 residents (national average of **56**).

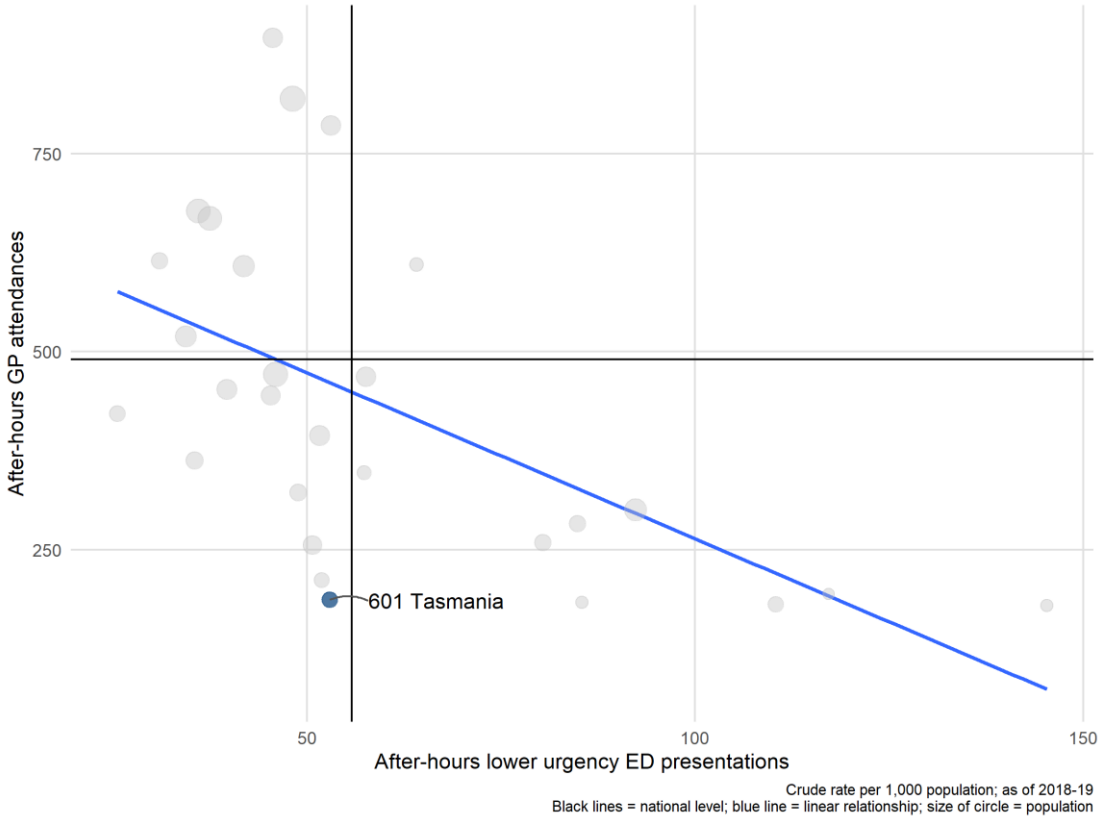

Figure 20 – GP after-hours services vs after-hours low-urgency ED attendances 2018–19

Sources: ED – Australian Institute of Health and Welfare (2020b); GP AH – Australian Institute of Health and Welfare (2020a)

Table 39 shows age standardised rates of GP after hours utilisation and ED presentations. This shows a similar pattern to the crude rates. GP attendances are below the national average and the average for regional PHNs. After-hours attendances are a lower percentage of total GP attendances than for all PHNs (3.8% compared with 8.3%). Low-urgency ED presentations both after hours and for all hours is close to the national average rate, but importantly lower than other regional PHNs.

Table 39– GP and lower-urgency ED attendances 2016–17 per 1,000 population, age standardised

	After hours GP	All hours GP	After hours %	After hours ED (Cat 4 and 5)	All hours ED (Cat 4 and 5)
Primary Health Tasmania	192	5,074	3.8%	56	122
Regional PHNs	290	5,597	5.2%	78	166
All PHNs	488	5,898	8.3%	58	120

Source: Australian Institute of Health and Welfare (2020b)

The MBS claims data does not include rural GP VMO attendances at smaller regional and rural hospitals as these payments are made by the Tasmanian Health Service. The lower rates of use in Tasmania may be partly attributable to dispersed rural and remote communities, fewer after-hours GP clinics, and the distance and travel time required.

Primary Health Tasmania

Primary Health Tasmania (PHT) is a company limited by guarantee and a registered charity. PHT replaced the Tasmanian Medicare Local on 1 July 2015. The Medicare Local was

established in 2011 and was operated by the General Practice Tasmania Network. PHT covers the whole of Tasmania, with offices located in Hobart, Launceston and Ulverstone.

PHT's strategic plan sets out goals grouped under five headings – health outcomes, person-centred care, provider capability and engagement, integrated primary health system, and value, effectiveness and efficiency.

The majority of PHT's funding is under a series of agreements with the Commonwealth Department of Health. From an initial base of around $11m, this funding has now grown to over $45m annually. Funding under the After Hours Funding Schedule has grown from $3.1m to $4.24m between 2015–16 and 2019–20. The evaluation notes that PHT had unallocated after-hours funding, with rollovers into FY 2018 of $455,000 and into FY 2019 of $980,000.

Total annual funding for the After Hours Program for the past two financial years is presented in Table 40. The Commonwealth Department of Health allocates funding to each PHN using a weighted population-based formula. Due to local factors (principally GP Assist), PHT has received additional funding.

Table 40 – Tasmanian PHN After Hours program funding

Financial year	Total After Hours allocated program funding (PHN)	After Hours funding per 1,000 population (PHN)	All PHN After Hours Program funding per 1,000 population	PHN ranking (After Hours funding per 1,000 population)
2019–20	$4,248,148	$8,394	$3,056	3rd
2018–19	$4,239,119	$8,376	$2,867	4th

After-hours primary care services

With most general practices closing at 5 pm or 6 pm, Tasmania has very few after-hours general practices. Hobart has a small number of after-hours general practices. These include the long-established, privately operated *After Hours Doctor* in Moonah, which is associated with the private company that runs GP Assist and which is funded by PHT to provide after-hours telephone triage services for Tasmania.

The Moonah Clinic is open 7 days a week, from 6 pm – 10 pm on weekdays, and 9 am to 10 pm on weekends and public holidays. Medical deputising services are available in the urban areas only.

With the COVID-19 MBS telehealth items, new telehealth and associated after-hours services have commenced in the urban areas. These include Your Hobart Health, an MDS providing home, clinic, telehealth and after-hours pharmacy services with free home delivery. The Your Hobart Health clinic is close to the hospital, with which it is hoping to establish a closer relationship to accept referrals from the ED. In Launceston, multiple extended-hours practices exist.

While some practices do provide after-hours services to patients, about 85% of Tasmanian general practices rely on the PHT-funded **GP Assist** service. The GP Assist phone line provides initial after-hours response and patient triage for patients. Typically, patients first call Healthdirect for triage. If their call is flagged as needing a GP or ED attendance, the call is transferred to GP Assist. In the January–March 2020 quarter, Healthdirect received 4,366 after-hours calls from Tasmania. Of these, 56% (or 2,425) were transferred to GP Assist.

Where the Healthdirect recommendation is to attend ED, the caller is warm transferred to the Tasmanian Department of Health-funded GP Assist nurse who performs a secondary triage and provides advice. If required, the caller is then transferred to the GP on duty for further assessment. Where the Healthdirect recommendation is to see a GP, the caller is transferred electronically to the GP Assist duty GP. The GP is able to provide a prescription, refer the caller to an after-hours clinic, arrange a home visit in urban areas if needed and, in rural areas, can contact the patient's GP to follow up with the patient if required.

Extended-hours community pharmacies are available in Hobart, Launceston, Burnie and Devonport. The main after-hours general practices and Medical Deputising Services are able to provide medication starter packs. Discussions with the PHT team, GP Assist and pharmacy organisations advised that there did not appear to be a significant after-hours access issue for pharmacy.

After-hours mental health services are not in scope for the evaluation. However, discussions with the PHT Team, Tasmanian Department Health and Ambulance Tasmania confirmed a growing demand for after-hours mental health advice. Ambulance Tasmania receives about 2,900 mental health-related Triple Zero calls a year[2], approximately 8 each day, 55% of which occur after hours. There did not seem to be a clear stepped model for the provision of mental health care in the after-hours period, with what appears to be a mixed picture of helplines, access lines and pathways to access mental health advice and services.

Consultations did not identify any after-hours access issue with, or service providers for, dental care or other allied health.

PHN approach

PHT After Hours Activity Work Plan 2017–19 summarised the strategic vision for their After Hours Program as:

> Primary Health Tasmania (PHT) will continue to work in collaboration with key stakeholders and where appropriate work in partnership to build on the work previously undertaken during the 2015–16 financial year in relation to identifying and addressing gaps in after-hours services, improve service integration and promote innovation and service redesign to ensure responsive solutions to access to care in the after-hours environment.
>
> PHT will continue to build on work commenced in 2012–13 around after-hours community needs for at-risk and vulnerable people through the After Hours Community Awareness and Education Campaign. This will include updates of the after-hours community website, mobile phone app and community resources regarding information about after-hours care and where and how to access services. PHT will continue to work with at-risk and vulnerable communities and other service providers to source feedback on after-hours service experience, gaps and opportunities for improvement and system innovation. A whole of health system community education and awareness partnership approach is being explored.

The updated 2019–20 PHT Activity Work Plan outlined seven key activities:

- AH 1: GP Assist
- AH 2: Evaluation of GP Assist
- AH 3: After Hours Community Awareness and Education
- AH 4: Paramedic and Community Nurse Project
- AH 5: Mobile Health Clinic Hobart
- AH 6: Needs assessment to determine requirement for extension of the mobile health clients to other vulnerable client groups
- AH 7: After Hours system reform.

The after-hours program funding allocation against these Activity Work Plan activities is shown in Table 41.

[2] 1,439 calls for 6 months Nov 19 to Apr 20 with 795 of these calls after hours (Calls coded Card 25: Psychiatric, abnormal behaviour or suicide attempt).

Table 41 – Tasmanian PHN After Hours activities and funding allocation

Priority Area	Funding allocated 2019–20	
	$	%
AH 1 GP Assist	3,011,426	78.8
AH 2 Evaluation GP Assist	86,041	2.3
AH 3 After hours community awareness and education	89,187	2.3
AH 4 Paramedic and Community Nurse Project	214,050	5.6
AH 5 Mobile Health Clinic Hobart	210,482	5.5
AH 6 Needs analysis expansion of mobile clinics	71,350	1.9
AH 7 After hours system reform	140,797	3.7
TOTAL	3,823,333[1]	100.0

[1] *Balance of funding is the PHN's administration allocation.*

Source: Tasmania Primary Health Network (2019)

What did this case study focus on?

In addition to general discussions with PHT and other stakeholders about after-hours service needs, and discussions with the PHT's team on the history of the after-hours program and its management, the evaluation team focused on three activities funded by PHT:

- **GP Assist** – the "flagship" program continued from the Medicare Local, with funding of $3.01m allocated by PHT.
- **Moreton Group Mobile Health Clinic, Hobart** – targeting a complex patient cohort who are disconnected and have difficulties in accessing primary care, with funding of $210,000 allocated by PHT.
- **Brighton Care Collective** – a community-development project involving a wide range of organisations in an outer urban area of greater Hobart. PHT contributed $40,000 towards the cost of the Collective's activities.

It was noted that in addition to the GP Assist flagship program, PHT had undertaken a range of community awareness campaigns, upgraded its website after-hours information and provided a mobile phone app ("Tas After Hours"). In earlier years, PHT had also funded a range of innovation projects.

Who did we interview?

In addition to the PHT chief executive officer, the senior management team and commissioned services contract managers, we undertook a mix of telephone and video interviews with:

- GP Assist executive team
- Healthdirect
- Ambulance Tasmania
- Tasmanian Department of Health
- A mix of urban and rural GPs
- Brighton Care Collective Project Manager
- Chief executive Moreton Group
- Pharmaceutical Society
- Pharmacy Guild
- Rural Health Workforce agency (HR Plus)
- Call the Doctor/Your Hobart Health (medical deputising service provider)
- A member of the PHT Community Council.

GP Assist

GP Assist is the PHT's flagship after-hours primary care service and accounts for almost 80% of the PHT After Hours funding program expenditure. Due to the level of funding required, PHT receives additional funding of about $2 million above the Department of Health's weighted population-based formula for allocating funding to each PHN under the After Hours program.

GP Assist's history

GP Assist has a long history in Tasmania. It emerged from a medical deputising service, After Hours Doctor (AHD), which started in Hobart in 1987 providing home visits and a dedicated stand-alone clinic for urgent after-hours consultations. At its peak in 1998, the AHD provided 13,000 home visits a year. The after-hours clinic provided over 20,000 services each year. While other medical deputising services operated, AHD was supported by the majority of Hobart general practices.

In 1999, the Commonwealth Department of Health called for expressions of interest from organisations/entities interested in developing innovative solutions in the provision of after-hours care. AHD applied and was successful in receiving a grant under this program.

With the burden of after-hours availability for rural doctors, AHD offered to extend the doctor triage service to rural GPs in southern Tasmania. The uptake of the AHD telephone triage by rural GPs in southern Tasmania was more than 80%. In the case of rural callers, the AHD doctor triaged the calls and only contacted the rural on-call GP if the caller required face-to-face care. The level of satisfaction by GPs and patients alike was very high. Rural GPs noted a more than 80% reduction in their after-hours calls.

Hobart urban home visits reduced to about 600 a year with the After Hours Doctor telephone service without complaint from callers. Following the success of the Southern Tasmanian After Hours Primary Medical Care Trial, AHD was invited to extend the service state-wide with the inclusion of nurse triage and advice as the initial step in providing the telephone advice. The state-wide service was called **GP Assist**. GP Assist began in October 2003 and operated under this model until 30 June 2013. Following the establishment of the Tasmanian Medicare Local, the core funding for GP Assist was transferred from the Commonwealth Department of Health to the Medicare Local.

Linkage with Healthdirect, July 2013

The Medicare Local undertook a competitive tender. In line with Commonwealth and Tasmanian Government policy, the nurse triage function was determined to be the role of Healthdirect. GP Assist became the contracted service provider with the Medicare Local from July 2013, providing the GP assessment function for callers referred from Healthdirect where Healthdirect had determined that the caller needed to see a GP within 2, 6 or 12 hours.

The service was promoted more widely in Tasmania with access being via the Healthdirect free call number. All calls were initially answered by registered nurses engaged by Healthdirect's contracted service provider on the Australian mainland. Calls were passed on to the GP Assist GP only if the triaging RN determined that the caller required same-day GP advice.

Within a short time, it became apparent that the broader scope of the previous GP Assist service model with its detailed local knowledge and its support of rural GPs and other health professionals and services had not been recognised, resulting in frustration for Tasmanian GPs and other health professionals and services. Further, Healthdirect's nurse triage service was recommending going to ED to a much higher proportion of Tasmanian callers.

- Consequently:

- The Tasmanian Medicare Local provided funding for a call handler (non-clinical) at GP Assist to receive all health professional calls. Health professionals could then telephone a dedicated number at GP Assist, bypassing Healthdirect.
- The Tasmanian Department of Health provided funding for a nurse to undertake a secondary triage of calls from Healthdirect with a disposition to go to ED.

The current GP Assist

GP Assist continues to provide a state-wide nurse (funded by the Tasmanian Department of Health) and GP (funded by PHT) telephone triage and advice service via a Hobart-based call centre. As shown in Table 42, about half of the after-hours calls to Healthdirect by Tasmanians are now being transferred to GP Assist.

Table 42 – Healthdirect Call Data April 2019 to March 2020, Tasmanian callers

Call category	Apr–Jun 2019	Jul–Sep 2019	Oct–Dec '19	Jan–Mar 2020
Total calls	8,603	8,995	8,575	7,329
Calls after hours	5,348	5,346	6,657	4,366
Calls transferred to GP Assist	2,918	3,077	2,997	2,425
% calls transferred to GP Assist	55%	58%	45%	56%

Some differences of view remain between GP Assist and Healthdirect:

- GP Assist is still concerned that Healthdirect's contracted provider's decision support software is too "risk averse".
- GP Assist also cites instances where Healthdirect's nurses do not have sufficient local knowledge of Tasmanian geography and rural primary care service and ED availability, resulting in incorrect advice.
- Healthdirect has noted the continuing need for Tasmanian general practices, after-hours clinics and rural and regional hospitals to ensure that the information in the National Health Services Directory remains timely and accurate.

The outcome data provided to PHT by GP Assist demonstrate that GP Assist seems able to address callers' urgent after-hours care needs and reduce the proportion of callers who need to attend an ED or see a GP on the same day.

Consistently around 55% of callers to Healthdirect are initially assessed as needing to see a GP within 6 or 12 hours (32%) or to go to an ED (23%). Following further triage by the GP Assist RN and, where required, assessment by the GP Assist GP, only about 40% of the transferred callers who had been initially advised they needed to go to ED ended up needing to be seen urgently at an ED. Based on the calls transferred from Healthdirect during 2019, there were just under 4,900 calls transferred where Healthdirect had recommended the caller go to an ED (around 13 per day). With the further GP Assist assessment, this represents 1,960 avoided ED attendances that year (around 5–6 per day).

Projected GP Assist call volumes this financial year are expected to be around 16,000. Of these calls, about 25% will be directly from health professionals and residential aged care facilities.

Table 43 summarises activity data from GP Assist's Jan–Mar 2020 report to the PHT.

Table 43 – Summary of GP Assist calls Jan-Mar 2020

Healthdirect ED call outcomes	Total this quarter	
	#	%
Ambulance	37	4.1%
ED	337	37.1
Rural on-call GP	13	1.4%
AHD/rural clinic	85	9.4%
Usual GP	194	21.3%
Scripts	10	1.1%
Home care	210	23.1%
No triage	23	2.5%
Total	**909**	
% diverted from ED	59%	

Healthdirect ED call outcomes	Total this quarter	
	#	%
Ambulance Tasmania	26	2.5%
Community hospitals	232	23%
Residential aged care	605	59%
Pathology	112	10.9%
Police	18	1.7%
Pharmacist	2	0.2%
Other sources	28	2.7%
Total	**1,023**	**100%**

Source: Unpublished data provided by GP Assist

While data on usage and outcomes of calls handled is readily available, the evaluation team did not have access to detailed costing analysis information. The evaluation team noted that GP Assist receives about $3 million each year from the PHT, a further $380,000 from the Tasmanian Department of Health and funding from the Tasmania Health Service and other organisations for specific services and projects.

GP Assist is a privately owned entity[3]. An associated entity operates the Hobart after-hours clinic[4]. This generates an income stream from subscriptions paid by general practices using the clinic for the after-hours care of their patients, patient payments, Medicare direct billing of pensioners and health care card holders, and potentially other MBS telehealth items for services provided separately to the GP Assist telephone triage service.

In 2019, Healthdirect transferred 11,650 calls to GP Assist. In its most recent quarterly report to PHT (Jan–Mar 2020), GP Assist projects annual total calls to be around 16,000. Around 25% of these calls are from health professionals. This suggests that the average cost per call to the PHT and Tasmanian Department of Health and Tasmanian Health Service is about $211, excluding the cost of the Healthdirect initial handling of the call. This suggests that the cost of managing the diverted ED attendances for the PHN and Tasmanian Department of Health is around $414,000 a year or $34,500 per month.

PHT commissioned the University of Tasmania's Menzies Institute for Medical Research to undertake an evaluation of GP Assist in October 2016 and July 2017.

The Neil et al. (2016) evaluation was a follow-up of earlier work undertaken for the Tasmanian Medicare Local. In addition to reviewing other service initiatives, the evaluation also examined satisfaction with GP Assist by GPs, practice managers and residential aged care facilities, and a financial analysis of management of calls transferred to GP Assist from Healthdirect with an attend ED recommendation.

This evaluation found dissatisfaction from general practices with the change in telephone triage arrangements upon commencement of Healthdirect, from calls going direct to the

[3] Medical Practice Management Solutions Pty Ltd (ABN 63 147 618 504) as trustee for the MPMS Telephone Triage Unit Trust (ABN 42 735 076 466).

[4] Medical Practice Management Solutions Pty Ltd (ABN 63 147 618 504) as trustee for the MPMS After Hours Unit Trust (ABN 96 294 073 451).

Tasmanian-based GP Assist nurse and GP triage system pre-2013, to the current position where all calls now go first to Healthdirect. The evaluation also noted high satisfaction from RACFs. The financial analysis noted a difference in disposition outcomes for rural and urban callers and attributed this to GP Assist's greater knowledge of rural and remote Tasmania and links with rural GPs, avoiding the need to attend an ED.

The evaluation estimated a monthly "saving" to the Tasmanian public hospital EDs of $60,743. This "saving" was based on specified costs of alternative outcomes (see Table 44).

Table 44 – Unit costs for outcomes of ED calls referred to GP Assist

Disposition		Unit cost ($)	% of Tasmanian GP consultations
Ambulance Tasmania		1,500.00	
Public ED		390.00	
Rural On-call GP[1]		129.80	
AHD/Rural Clinic[1]		129.80	
Usual GP:			
	Level A	16.95	5%
	Level B	37.05	79%
	Level C	71.70	15%
	Level D	105.55	1%
Prescription		0.00	
Home care		0.00	
No triage		$390.00	

Note: 1. Item 597, 100% rebate. Source: Neil et al. (2016, p. 32) using data from Ambulance Tasmania, Department of Health & Human Services, MBS 1 April 2016.

The costing study used average costs for ED attendances and did not consider the costs to both the Tasmanian and Commonwealth Governments of funding Healthdirect and GP Assist.

The 2017 evaluation (De Graaff et al., 2017) revisited the three areas from the 2016 evaluation and followed the change to transfer an agreed subset of Healthdirect calls to GP Assist (calls where Healthdirect recommendation was to see a GP within 12 hours or attend an ED). The 2017 report found increased satisfaction by general practices (more so with the GP Assist component of the pathway than the initial nurse triage component delivered by Healthdirect) and continued satisfaction from RACFs.

This evaluation found that the estimated monthly savings to the Tasmanian public sector EDs was in the range of $38,000 to $50,000. The evaluation used the same costs as in the previous year's evaluation. Again, the evaluation did not examine the costs to the governments of funding Healthdirect and GP Assist. The range of cost savings are slightly higher than the estimated savings of $34,500 per month derived from the 2019 figures set out above.

There is clearly a saving to hospitals if the number of ED attendances fall. However, this saving is at the margin unless there is a step change reduction that leads to a reduction in staff numbers in the ED. The ED attendances diverted by GP Assist will also have, on average, a lower acuity.

Other services provided by GP Assist

With funding from the Tasmanian Department of Health, GP Assist continues to support home palliative care services and community nurses after hours working with the Community Rapid Response Service.

Feedback from GPs and other organisations

The evaluation team talked with numerous GPs and GP organisations, the Tasmanian Rural Health Workforce Agency, Ambulance Tasmania and the Tasmanian Department of Health. All very strongly supported continuing the GP Assist service model. Rural GPs in particular and the Rural Health Workforce Agency pointed to a significant and sustained fall in the number of after-hours calls and call-outs for rural GPs. The Rural Health Workforce Agency advised that the existence of GP Assist was a major drawcard in recruitment and retention of rural GPs in Tasmania.

Moreton Group Mobile Clinic Hobart

Launched in late 2016, the Moreton Group Medical Service mobile health clinic was commissioned by PHT to improve access to after-hours medical care for vulnerable clients of community service providers in Hobart. The funding provided by PHT in 2019–20 is $210,482. The Moreton Group Medical Service is part of the Moreton Group, a business providing first aid training, medical and paramedic services for events, and non-emergency patient transport.

PHT was seeking ideas and proposals under an innovation grants program and the Moreton Group submitted a proposal, which was accepted by the PHT. After a 6-month trial, which received very positive feedback, the PHT then entered into a longer-term commissioned services contract to maintain the service. The funding has remained at the same level over the past 4 years. The PHT funding contributes to the infrastructure and running costs of the mobile clinic. These costs are supplemented by MBS income, the Morten Group company, and other grants and funding sources.

Operating from 6–10 pm Monday to Friday, the Moreton Group Medical Service mobile health clinic is available free of charge to people accessing emergency and transitional accommodation, homelessness services, foster care, supported accommodation and disability services. Each evening the clinic is based on a rostered basis at NGOs across various locations. The clinic will also respond to urgent calls from NGOs.

The mobile clinic clients have complex health and social needs, often coming from a background of displacement, abuse and disadvantage, and disconnected from or unable to access mainstream health and medical services. Many are homeless or at risk of homelessness. They often have no regular GP. They have health literacy issues and/or social or behavioural issues that also make it difficult to access support. The clinic describes its service as "homeless medicine", providing community-based medical care in a non-judgmental environment where people feel safe and secure.

The project involves collaboration with a range of community groups including Anglicare, the Bridge Program, the Salvation Army, Loui's Van, Small Steps, Colony 47's Mara House, Hobart City Mission, St Vincent de Paul and the Hobart Women's Shelter.

The clinic is more than a general practice service. The GPs and support workers work closely with the non-government community organisations to assist clients with their accommodation, mental health, income support, food, and alcohol and other drug rehabilitation needs.

The mobile clinic has attendances of around 15 to 20 clients each week. While the goal is to connect clients to mainstream general practice, if this is not possible, clients are able to return for follow-up appointments. Medical services are provided by general practitioners and bulk billed. The clinic relies heavily on the goodwill of the participating GPs and GP registrars.

The Moreton Group advised there had not been significant changes to the PHT contract other than that client access had been broadened to enable any Hobart NGO to refer a client who did not have a regular GP. The Moreton Group would like to receive funding to

enable the clinic to provide services to this vulnerable population group during in hours as well as after hours.

The PHT contract requires quarterly utilisation, referral source, service type and client demographic information. While data is not available to provide information on longer-term client outcomes, the clinic is able to provide qualitative information on many client stories. Periodic surveys have been undertaken to see where clients would have gone if the mobile clinic was not available. In addition to not accessing any service, responses indicated that they would have tried the Royal Hobart Hospital ED or called an ambulance.

The evaluation team saw the mobile clinic as a successful example of an innovative idea developing into a longer-term funded service meeting an important gap in access to primary care services for a vulnerable population group. While operating as an after-hours primary care service, the desire of the Moreton Group to extend the service into the "in hours" is another illustration of the tension between addressing a gap and complying with the stated objectives of the After Hours funding program.

The Group had also recommended to PHT that consideration be given to funding a similar service in northern and north west Tasmania. PHT invited Moreton Group Medical Service to extend its service to those areas, but the Group was not in a position to do so.

Brighton Care Collective

A Brighton LGA snapshot

The Brighton LGA is located in the outer north east region of greater Hobart and is one of five LGAs in greater Hobart. With a current population of 16,600, Brighton's population has grown over recent years. The projected population by 2033 is 24,000. The community is younger than the other LGAs and has lower socio-economic outcomes with lower household incomes and a higher unemployment rate. The LGA includes urban and rural areas with an industrial estate adjacent to the River Derwent at Bridgewater.

Transport, warehousing and logistics is a major employer, concentrated in the Bridgewater Industrial Estate. There are numerous social housing developments across the LGA with 32% of dwellings rented from the State housing authority. Car ownership is lower than across Hobart generally and the inadequacy of public transport – none available after hours – has been frequently raised as an issue in community consultations.

There are three general practices in the LGA, two in Brighton and one in Greenpoint. Neither of the Brighton practices are open on the weekend. The Greenpoint practice opens on Saturday mornings. A check of next available appointments on Healthdirect indicated a 2-day wait. After hours, residents have access to the GP Assist telephone triage service and a medical deputising service (but only to the adjacent Hobart suburbs and not smaller communities). The nearest after-hours GP clinic is the GP Assist-associated clinic in Moonah. If an attendance at the Royal Hobart Hospital is required, the road trip is 25km by car or ambulance.

Brighton Care Collective Services

The Collective was formed in 2017 after funding by PHT to the Brighton Council. The PHT funding was a community development initiative with the objective of better connecting care in selected communities. Including the Council, the Collective now has 20 members drawn from a range of social support, housing, health and community organisations.

The Collective operates under the following Guiding Principles:

- Strengthening connections with other members of the Brighton Care Collective.
- Improving access to primary health care and health-related community services in the Brighton municipality.

- Improving the quality of coordination of healthcare and health-related community services within the Brighton municipality.
- Ensuring that community members seeking health information are referred to the most appropriate health care service within the Brighton municipality.
- Sharing relevant service provision information to all members of the Brighton Care Collective.

The Brighton Care Collective member organisations share service delivery information to develop a deeper knowledge of each other's services and referral processes. The organisations agree to provide warm referrals and run through a checklist with people to assist in overcoming any non-health-related barriers that could prevent them accessing a service. In addition, the organisations will follow up to ensure consumers have taken up the referrals and provide ongoing support, if required.

Brighton Council provides in-kind support including access to office space and meeting rooms. Using an underspend rollover, PHT has provided funding of $40,000 in 2019–20 to support the cost of the project officer and associated expenses.

The evaluation team was advised that the main achievements to date have been:

- services now know each other
- the creation of an online Brighton Services Directory
- lobbying for local provision of services to reduce the need for residents to travel into Hobart for appointment, with some Hobart-based services now providing outreach clinics in Brighton.

The Collective would like a more comprehensive health centre in Brighton with services including imaging and adult dental health. Transport remains an issue and after hours, if needing to go to a service in Hobart and the person does not have access to a car, calling an ambulance is often the only alternative.

The Collective provides quarterly reports to PHT and the contract deliverables are received and monitored through the Health System Business Unit. PHT advised that the funding for the Collective was originally sourced from other funding schedules and was then moved to the After Hours Program as part of the AH 4 Paramedic and Community Nursing activity in the PHT Activity Work Plan. However, due to competing priorities in Ambulance Tasmania and community nursing and the COVID-19 pandemic, this activity has not progressed. PHT also wished to maintain its funding to enable the Collective to continue its role with the Tasmanian Department of Health Care Point Trial supporting care coordination and case management for frequent users of hospital services, both in hours and after hours.

While acknowledging the importance of community development and the potential of the Collective to lobby to improve in-hours primary care services and access, the evaluation did not see this PHT-funded program as falling within the Department of Health's stated objectives for the After Hours funding program.

Improving the Program

Arising out of the interviews and review of background material, the evaluation made the following observations:

Opportunity to develop a co-ordinated after-hours Tasmanian primary care plan

Although there is one PHN, one Department of Health, one hospital and health service (the Tasmanian Health Service – soon to be split into two), one ambulance service and a range of state-wide organisations serving a population of 535,000, there is not a coordinated, system-wide plan for after-hours primary care in Tasmania.

Ambulance Tasmania is actively progressing development of its own secondary triage call system. The Department of Health and Tasmanian Health Service are developing a rapid response community clinical support service for people at risk of hospitalisation due to

deterioration in their chronic health condition or other acute event (Community Rapid Response Service). The Tasmanian Government has made an election commitment to establish two Urgent Care Centres.

The medical deputising services and the new post COVID-19 telehealth services operate independently.

After-hours mental health issues are handled separately by the Tasmanian Health Service, Ambulance Tasmania, mental health NGOs and GP Assist.

PHT advised that they see their main role in the primary care after-hours space as filling the primary care after-hours 'gaps' against a background of a very widely distributed population living outside of Hobart and Launceston, the fragility of sustaining rural general practice and the difficulty of meeting the needs of remote communities. PHT advised that there have been many discussions with the Tasmanian Department of Health, the Tasmanian Health Service and Ambulance Tasmania over the past 3 years on developing a joint after-hours service plan and associated service reform to develop a better, more integrated and cost-effective service. However, they have not gained traction.

There is clearly an opportunity to explore greater integration of the GP Assist service, after-hours GP clinic services, Healthdirect, other telehealth services, Ambulance Tasmania secondary triage and ED triage.

This exploration should take advantage of the experience of other PHNs, states and territories, and overseas countries. HNECC PHN has GP Access, Western Australia is trialling urgent-care centres, while the Australian Capital Territory is expanding its nurse walk-in clinics. In the Netherlands, for example, non-emergency patients are required to ring the GP Access equivalent in their area before presenting to the ED. From a patient perspective a very different system might emerge, one where the person (patient, family member or carer) makes a single call and ends up with their issue addressed at the lowest level of care appropriate, starting with virtual care then moving to face-to-face options, but all within an integrated system.

Telephone triage integration and functionality

While relations between Healthdirect and GP Assist have improved since July 2013, when Healthdirect became the initial stage of the caller pathway, it is clear that some tensions remain. Ambulance Tasmania funds a mental health nurse to undertake secondary triage of Triple Zero calls and is now actively pursuing implementation of a broader nurse secondary triage system for Triple Zero calls. The medical deputising services and the new post COVID-19 telehealth services operate independently.

Data from both GP Assist and Ambulance Tasmania suggest that an effective telephone triage system can manage a significant proportion of calls without the need to arrange a home visit, attend an ED or dispatch an ambulance.

There is an opportunity to better shape telephone (and other forms of telehealth) triage into an integrated service in Tasmania, incorporating Ambulance Tasmania secondary triage, servicing of the residential aged care sector, arranging appointments with after-hours clinics, medical deputising home visits, and next-day, in-hours general practices.

The evaluation team were made aware by various stakeholders that a review of recent incidents in the Tasmanian after-hours primary care Linkage Service had been performed in response to clinical governance issues raised by GP Assist and PHT over the disposition given by Healthdirect for a number of calls. The review report was not made available to the evaluation. It is understood that one of the review recommendations was a reconsideration of the current contractual arrangements, noting that the current system of multiple contracts, handoffs and players was complex and may be generating additional risks for patients and costs in administration and duplication.

The evaluation noted that in the Lower Hunter Valley in NSW, the GP Access triage service locally manages all calls received by Healthdirect. It also integrates with the Aged Care

Emergency service, handling calls after hours, and provides support to Central Coast After Hours GP Clinics. A comparison of features of the two programs is summarised in Table 45.

Table 45 – Comparison of GP Access (HNECC PHN) and GP Assist (Primary Health Tasmania)

Feature	GP Access	GP Assist
Ownership	Hunter Primary Care, a company limited by guarantee	Privately owned entity
Linkage with Healthdirect	No formal arrangement exists	Only calls triaged with ED disposition or see GP within 12 hours are diverted to GP Assist call centre
Funding of call centre	PHN funds nurse and GP on call for GP Access call centre	Tasmanian Department of Health funds nurse and PHN funds GP on call and majority of the operating costs for GP Assist call centre
Ambulance triage of calls	GP Access does not provide secondary triage service for NSW Ambulance. Healthdirect provides this service for NSW.	GP Assist does not provide secondary triage service for Ambulance Tasmania
Geographical coverage	Only the Lower Hunter sub-region of the PHN, albeit the most populous	Whole of PHN
Use of service by rural GPs	Rural GPs in other subregions rely on GP visiting medical officer arrangements and regional hospital support	Strong GP Assist focus on supporting rural GPs by providing telephone-based deputising service for participating rural GPs
Residential aged care facilities support	Focus on supporting residential aged care facilities via integrated program of training and protocols under the Aged Care Emergency service	Support is provided to residential aged care facilities by GP Assist
Staffing	Cooperative roster of local GPs run 5 integrated and co-located after-hours clinics	Relies on privately owned after-hours clinics in urban centres – Hobart and Launceston
Bulk-billing GP clinics?	Yes	Privately owned after-hours clinics – not 100% bulk billing
Appointment booking?	GP Access makes direct booking with clinics for direct and ambulance calls	GP Assist refers callers to available clinics to make their own appointments
Linkage with ED	Well-integrated system of referral between public ED and GP Access clinics.	EDs are not integrated with GP Assist or with local after-hours GP clinics
Support to other health professionals	GP Access provides support to residential aged care facilities but not to other services	GP Assist provides separate telephone advice to other health professionals and services (about 25% of calls)

"In-hours" issues are having an impact on after-hours demand

Many people and organisations interviewed, including Ambulance Tasmania, raised access issues "in hours" as a contributing factor to after-hours demand, including avoidable attendances at EDs. These issues include limited access to bulk-billing general practice, availability of public transport, and care co-ordination and support for people living with chronic or complex conditions.

Assessing the cost effectiveness of GP Assist

GP Assist clearly meets a need and the service is strongly supported by GP organisations, the Rural Health Workforce Agency, rural GPs and the Tasmanian Department of Health. PHT sees the type of model delivered by GP Assist as a fundamental pillar supporting and stabilising rural general practice in Tasmania.

The evaluation team agrees that a well-organised, locally based nurse and GP telephone triage service should be maintained to provide a coordinated and clinically appropriate service to callers, appropriate demand management, and to support GPs after hours, especially in rural areas. As noted in the observations listed above, there are also opportunities to embed the service in an integrated primary health care plan for Tasmania and explore greater integration of the GP Assist service, after-hours GP clinic services, other telehealth services, Ambulance Tasmania secondary triage and ED triage.

There would be great value in the Tasmanian Department of Health engaging with PHT to undertake a joint and more comprehensive cost effectiveness evaluation of GP Assist. This evaluation should consider costs borne by the Commonwealth and State Governments and by patients and include any discernible impact on in-hours and after-hours service utilisation.

Review GP Assist service

Subject to the outcome of the Commonwealth Department of Health's review of the PHN After Hours Program, and confirmation of longer-term funding, it would be opportune for PHT to undertake a review of the service in conjunction with the Tasmanian Department of Health.

Some stakeholders interviewed felt that PHT was "GP centric" and primarily focused on GP Assist and existing after-hours general practice providers, making it difficult for alternative service providers to access the market. A review process could inform a process to test the market for the service.

Potential opportunities for consideration in the review might include:

- linkage with Ambulance Tasmania's proposed secondary triage service
- incorporation of a wider telehealth capability
- trial of telephone triage of low-acuity patients presenting to Hobart & Launceston EDs
- support of Hospital in the Home services
- greater use of other after-hours GP services and telehealth services.

This process would also facilitate greater transparency with the recent change in ownership of both GP Assist and the After Hours Doctor clinic in Moonah to Better Medical, a South Australian private company[5].

Stakeholders consulted and survey responses

Table 46 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other
PHT	6		
Moreton Group		1	
Brighton Collective			1
GP Assist		4	
Local General Practitioners			3
Pharmaceutical Society of Australia			1
Pharmacy Guild of Australia			1

[5] Founded in 2015, Better Medical is a private company headquartered in Adelaide that operates 29 GP clinics in South Australia, Queensland and Tasmania. It has a number of GP shareholders together with private investors. In December 2019, Better Medical acquired both the GP Assist and the Hobart After Hours Doctors clinic entities, together with another four GP clinics in Tasmania. See www.bettermedical.com.au.

Call the Doctor			1
Community Advisory Committee			1
Healthdirect			3
Tasmanian Department of Health			2
HR+			1
Ambulance Tasmania			1
Total	**6**	**5**	**15**

Table 47 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider surveys	1

9 Northern Queensland PHN

Case study scope and focus

The Northern Queensland PHN case study was **geographically based** focused on the areas of the **Tablelands and Bowen**.

What were the key observations from this case study?

What we learnt:

- There is **complexity in filling gaps in after-hours access, especially when these exist at a micro level.** Where some limited mainstream after-hours services are available in a locality, it can be difficult to commission a service that works around existing provision and effectively targets a small number of patients in specific localities.
- Stakeholders queried whether it made more sense to **rely on the ED** when patient volume and demand for after-hours services were low.
- **Systemic workforce and recruitment issues** exist throughout the region, especially in rural and remote areas. This, coupled with a reluctance of local GPs and other health professionals to work after hours, makes it difficult to improve after-hours access throughout Northern Queensland PHN.
- Stakeholders have called for increased engagement and collaboration from Northern Queensland PHN especially regarding the design of services that consider and acknowledge **existing after-hours service arrangements**.
- **Access problems are not limited to after hours, patients also face significant barriers to in-hours primary care**. Many practices were no longer accepting new patients, which leaves individuals with limited or no access to a regular GP in certain areas. There is also a lack of bulk-billing services in Northern Queensland PHN.
- The complexities of the MBS system, and the financial incentives that a fee-for-service reimbursement model creates, make it difficult for the Northern Queensland PHN to subsidise and promote deputising or other services without running the risk of being seen to undermine competition or the livelihood of other providers.

Locality overview

The Northern Queensland PHN is one of the larger PHNs by area and covers about 500,000 square kilometres (Northern Queensland Primary Health Network, n.d.). The PHN supports primary care services across the area, which stretches from the Mackay region in the south to Cape York and as far as the Torres Strait in the north. The PHN has a population of 668,147 (2016) residents with around 70% concentrated in the regional centres of Cairns, Townsville and Mackay.

The majority of the Northern Queensland population (81%) live in areas categorised as outer regional, 8% of inhabitants reside in remote or very remote areas and the remaining 11% live in inner regional areas (Mackay).

- Cairns – 152,852 residents – Outer regional (MMM 2: regional centre).
- Townsville – 185,904 residents – Outer regional (MMM 2: regional centre).

- Mackay– 114,384 residents – Inner regional (MMM 2: regional centre).

The area along the coast is mainly classified as MMM 5: small rural towns with the hinterland classified as MMM 6: remote and the far north Cape York peninsula as MMM 7: very remote. Among those areas there are some regions classified as MMM 4: medium rural towns, such as Atherton and Mareeba in the Tablelands and Bowen on the coast between Townsville and Mackay.

Northern Queensland is a diverse region. The coastal area is popular for tourism, and agriculture and mining are major industries. Aside from the three main towns, there are many smaller country towns across the region, including the towns around the Atherton Tablelands and those dotted down the coast. About 7.5% of the population identify as Aboriginal and Torres Strait Islander peoples.

The PHN area covers 31 local government areas, four Queensland Hospital and Health Service (HHS) areas and nine Aboriginal medical services. Health service delivery is often grouped by locally defined regions.

Figure 18 illustrates health region boundaries and key townships and communities. Provision of after-hours services within the PHN comprises the following features:

- Limited GP practice after-hours services – fee-for-service or bulk-billing mainly in towns.
- An after-hours clinic within a private hospital in Cairns.
- After-hours public hospital – ED.
- After-hours services in remote clinics provided by ACCHS.
- After-hours medical retrieval provided by the Royal Flying Doctor Service.
- After-hours nurse and GP telephone helplines.

Of the 35 population health areas (SA2) within the PHN, 11 have no GP after hours in the vicinity (Larter Consulting, 2020).

Figure 21 – Map of the Northern Queensland PHN

Source: Department of Health (2015)

In comparison to the 31 PHNs in Australia (Australian Bureau of Statistics, 2016a), the Northern Queensland PHN is ranked:

- **6th** in terms of geographic areas covered
- **15th** in terms of the total population supported
- **3rd** in terms of Aboriginal and Torres Strait Islander peoples supported.

Figure 22 presents data demonstrating that relative to other PHNs' access to primary health care in the after-hours period:

- The Northern Queensland PHN ranked **17th** of 31 PHNs for GP after-hours attendances with **363** per 1000 residents (national average of **490**)
- The Northern Queensland PHN is ranked **4th** of 31 PHNs for after-hours low-urgency ED attendances with **33** per 1000 residents (national average of **56**).

The case study focuses on the Tableland and Bowen areas, shown as CS7 in Figure 22. These areas have significantly lower GP after-hours attendances than both the PHN as a whole and the national average. There are also fewer low-urgency ED presentations than the PHN overall or the national average.

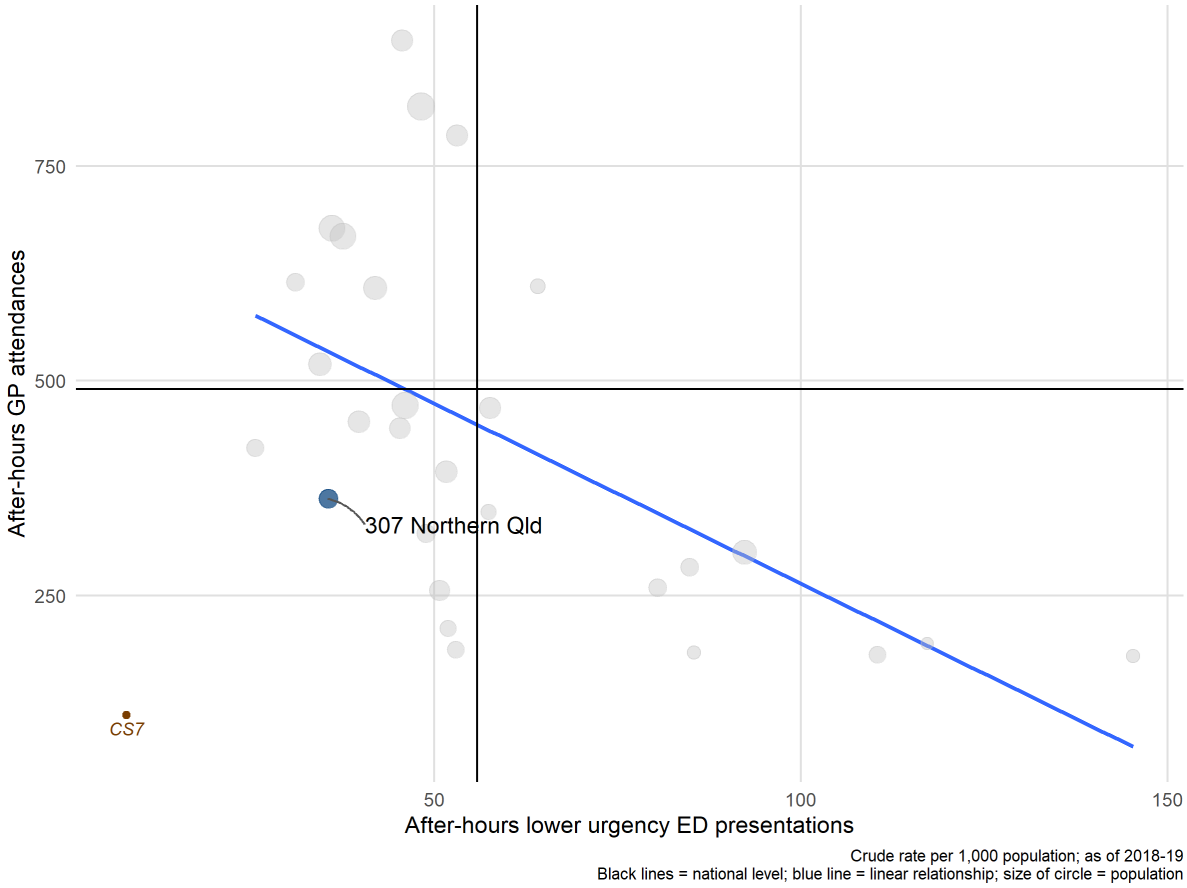

Figure 22 – GP after hours versus ED low urgency presentations, 2018–19

Sources: ED – Australian Institute of Health and Welfare (2020b); GP AH – Australian Institute of Health and Welfare (2020a)

Commissioned providers

Two commissioned services operate in the case-study areas, collectively receiving $1.75m annually from the PHN After Hours Program, representing 33% of the total 2019–20 Northern Queensland PHN after-hours budget. One service operates only in Mareeba area.

Key population and health data relevant to the understanding of the case study:

- Atherton and Mareeba are located 30 km apart on the plateau of the Atherton Tablelands, which forms the Great Dividing Range about 100 km inland of Cairns. The area is predominately agricultural mixed with rainforest.
- Atherton has a population of 10,708 but serves a wider population of around 40,000. Mareeba is at the northern end of the Tablelands and has a population of 11,079. The area is categorised 4 on the MMM classification and considered "medium rural towns", although the towns serve a wider remote (and challenging) geography. The area is classified as Australian Statistical Geographical Classification – Remoteness Area 3 (ASGC-RA3) 'outer regional' under the Australian Standard Geographical Classification.
- Bowen is a seaside town, north of Mackay and close to the Whitsunday Islands. The area surrounding Bowen is agricultural. It has a population of 9,105.
- The Index of Relative Socio-economic Advantage and Disadvantage for Atherton and Mareeba are 958 (decile 3) and 919 (decile 2) respectively, and for Bowen is 916 (decile 2) (Australian Bureau of Statistics, 2016f).

Health services within the case study service setting/locality

After-hours service provision is relatively limited in these three towns and broadly comprises:

- A limited number of GP practice after-hours services – normally fee-for-service or bulk-billed for certain patients.
- A public hospital ED in each of the three towns.
- A 24/7 primary care service in Cairns (70–100 km from Mareeba and Atherton), but nothing similar near Bowen.

Table 48 provides a high-level summary of the services operating within the case study site drawn from the Health Directory on the Healthdirect website.

Table 48 – Service types in each area

Type	Type, number and service parameters	
	Bowen	Atherton and Mareeba
Private GP practices	3 GP clinics listed on Healthdirect.gov.au in Bowen. All provide mixed billing arrangements. One practice is run by a community cooperative with a specific focus on Indigenous health, but the practice is open to all. Bulk billing is offered to some patients.	3 GP clinics listed in Atherton and 3 GP clinics in Mareeba. None offer bulk billing in either town, but we know from stakeholder interviews that this is offered to certain patients.
Medical deputising services	None	None
Aboriginal Community Controlled Health Services (ACCHS)	The practice in Bowen run by the community cooperative provides primary care services for Indigenous people in the Bowen area.	A variety of services are available in Atherton and a primary health care centre in Mareeba. One after-hours service delivered by Mulungu Aboriginal Corporation is funded by the PHN to provide a service in Mareeba.
Pharmacies	2 pharmacies listed on Healthdirect.gov.au in Bowen.	8 pharmacies listed on Healthdirect.gov.au. and in the Northern Queensland needs assessment (Larter Consulting, 2020). This includes the pharmacies at the two hospital sites which have more restricted hours.
Public hospitals & EDs	Public hospital with 24-hour ED.	Public hospital with 24-hour ED in both Atherton and Mareeba.

Type	Type, number and service parameters	
	Bowen	Atherton and Mareeba
Private Hospitals & EDs	None	None (Cairns is closest)
Nurse and GP telephone helplines	13 HEALTH nurse triage service (Queensland Government).	13 HEALTH nurse triage service (Queensland Government).
Other	None	None

What options are available to access after hours?

The needs assessment commissioned by Northern Queensland PHN (Larter Consulting, 2020) showed that 11 of 35 population health areas (PHAs) within the Northern Queensland PHN catchment had no access to after-hours services and only 4 PHAs had general practices that were open seven days a week during select after-hours periods. Consumers cited numerous barriers to accessing after-hours care, including workforce shortages making it difficult to book appointments in-hours and after hours and have access to a regular GP, limited after-hours services within a consumers' residential area, transport, cost, and cultural acceptability and appropriateness. The majority of practices and community pharmacies throughout the catchment were not offering after-hours services. The private hospital in Cairns had recently opened an urgent-care centre, and there were some additional options in Townsville, but for many areas the local hospital was the main provider of after-hours care. The needs assessment reported that the Cape York and Torres Strait region is relatively well served by ACCHS and the Royal Flying Doctor Service (RFDS) (Larter Consulting, 2020).

The needs assessment provided the following findings and recommendations in relation to after-hours service provision in the Northern Queensland PHN region. These are listed in Table 49 (Larter Consulting, 2020):

Table 49 – Problems and recommendations identified in Northern Queensland PHN After Hours needs assessment

Problems and suggestions identified	Summary of recommendations
Limited after-hours services available in Northern Queensland, specifically in Mackay and surrounding areas.	• Expand services of Telehealth Doctor NQ to entire PHN region. • Provide grant funding to general practices and community pharmacists (excluding Cairns) to extend opening hours to 8pm. • Support 'co-responder' after-hours mental health model in Mackay and Townsville areas. • Develop workforce recruitment strategies for GPs, mental health workers, and pharmacists. Expand partnerships with local universities or promote nurse-type models of care to allow practices to extend operating hours.

Limited community awareness of after-hours services available within the PHN region.	• Support community awareness campaign on after hours that highlights key services available in the community such as 13SICK, Telehealth Doctor NQ, etc.
	  ○ Ensure that the campaign is available in different languages and is culturally appropriate
	  ○ Campaign focus on those over 65 and parents with young children
	• Make updates to "Sick After Hours" PHN website

Issues around lack of transport, which is also a financial barrier for certain residents seeking after-hours care.	• Collaborate and establish partnerships with HHSs and taxi services to provide after-hours transport assistance to residents who have limited to no access to transport.
Limited in-hours chronic disease management services available for residents, which	• Establish a PHN framework that reviews education and training resources on integrative models of care and chronic disease management for primary care providers

Problems and suggestions identified	Summary of recommendations
may lead to higher demand for after-hours care.	• Ensure that provides are able to easily access these resources and training materials. Provide additional supports and resources to consumers to help them effectively manage their chronic conditions.
Further opportunities to collaborate with practices and pharmacies to identify and create local innovative models of care to address these issues.	• Explore opportunities to establish a 'roster/patient streaming service model'.

The needs assessment also pointed out that the availability of services in part reflected the relatively low number of GPs in the region – 97 GPs per 100,000 residents compared to 154 per 100,000 across the state and 143 per 100,000 nationally (Larter Consulting, 2020).

In Mareeba, after-hours services are limited to an evening clinic one day a week and some Saturday mornings. Northern Queensland PHN's needs assessment stated there was no after-hours coverage in Atherton (Larter Consulting, 2020), however, it was reported by an interviewee that there are three practices operating a joint rota to cover the after-hours period for patients attending those practices, however, the service is not bulk-billed.

Bowen has no after-hours primary care services. The large transient population (agricultural workers) also has limited access to in-hours primary care. Of what is available, one clinic offers a range of targeted services for the Indigenous population. The clinic is open to all, however, only bulk bills indigenous patients and health care card holders. The clinic operates from 7 am on Thursdays and Fridays by way of extended hours. The organisation would like to expand its service hours to a weekly, men-only evening clinic, not for urgent-care needs, but to target 'working men' who the service believes tend to defer health screening and investigations to their detriment. The clinic is also considering Saturday morning trade to accommodate existing patient demand. Beyond these extended hours, the organisation did not see a great enough demand for after-hours care in Bowen to warrant opening during unsociable hours (i.e. past 11 pm).

In Mareeba, the prevailing view was that the local hospital was providing an effective after-hours service that provided good feedback to GP practices. Therefore, there was no need for any additional services in the community. The good hospital–GP relationships did not appear to be replicated in Atherton or Bowen, where the link back to practices was reportedly less effective. 'They're too busy,' was one respondent's view.

Although Atherton had managed to maintain a 24/7 after-hours rota across 10 doctors in the 3 local practices, this arrangement is only available to patients who can afford the $150 cost. GP recruitment problems in Atherton (as well as the other two case study sites) meant many of the practices were not taking on new patients. This meant there were many patients who could not find or afford a GP in normal hours. *"Beyond 9 o'clock, the hospitals are the default service"* [Local Stakeholder]. GPs stated that they bulk bill patients they knew could not afford the out-of-pocket costs; however, this was reliant on the fact that GPs or practices knew of a patient's financial position, and patients in the position of knowing they would be bulk billed if they presented.

Some of the GPs in practices with no formal after-hours arrangements said they provide after-hours care for high-need patients, such as those receiving palliative care or at the end of life. They will also take phone calls relating to the management and treatment of residential aged care patients. One result of the implementation of the COVID-19 MBS items was that these consultations were now seen as being reimbursed whereas they were not previously.

Stakeholders generally welcomed the introduction of the telehealth MBS items, especially as they can increase access for patients such as those living in rural and remote areas, those

with limited access to transport, and older residents. Despite these positive reflections, stakeholders acknowledged there needed to be parameters and/or restrictions placed on the use of the MBS items to combat the potential for abuse. There was also some confusion around existing GP arrangements, as rural GPs often work in local hospitals and general practice creating uncertainty as to when and where they could claim telehealth items.

PHN approach

Total annual funding for the PHN's After Hours Program for the past two financial years is presented in Table 50. This indicates that on a population basis, the Northern Queensland PHN received a greater share of funding than most PHNs.

Table 50 – Summary of Northern Queensland PHN After Hours funding

Financial year	Total After Hours allocated program funding (PHN)	After Hours funding per 1,000 population (PHN)	All PHN After Hours Program funding per 1,000 population	PHN ranking (After Hours funding per 1,000 population)
2019–20	$5,281,958	$7,905	$3,056	5th
2018–19	$5,812,958	$8,700	$2,867	3rd

The Northern Queensland PHN would like to move to a more integrated approach to service development and funding as opposed to a 'siloed' program-by-program approach that was previously undertaken. The PHN reported that the siloed nature of the after-hours funding has made longer-term integrated investment in local health services more difficult. In 2018–19, Northern Queensland PHN decided that the after-hours funded services were not well targeted, so Northern Queensland PHN decided to 'pause' funding and conduct a review.

Northern Queensland PHN stated that they have been working towards increased stakeholder collaboration and engagement across the board and did not want to simply engage in a 'box-ticking' exercise. Northern Queensland PHN also reflected that, though they have strong partnerships with some HHSs, developing and maintaining relationships with all four diverse HHSs across the catchment has been a challenge.

One of the PHN's activities in 2019–20 was the funding of an external consultant to develop an after-hours strategy and implementation plan. The report was still being finalised during the course of the case study, but the draft findings pointed to the need to improve the low recognition of service availability in the community.

The Activity Work Plan set out the 'opportunities, priorities and options' for Northern Queensland PHN as:

- improving access to after-hours health services
- improving coordination and collaboration across the region
- improving integration and coordination of care for better health outcomes in the after-hours period
- performing systems evaluations and engaging in strategic partnerships to produce expected outcomes
- increasing community knowledge and understanding of the primary care system, health behaviours, Aboriginal & Torres Strait Islander health
- increase after-hours access in remote areas, especially for Indigenous people in Cape York and Torres Strait.

Table 51 shows the after-hours activities from the Activity Work Plan for 2019–20 to 2020-21 (Northern Queensland Primary Health Network, 2019a).

Table 51 – Northern Queensland PHN-funded activities from Activity Work Plan

Priority area	Funding allocated 2019–20		Represented in case study
	$m	%	
After Hours Needs Assessment and Strategy Development	$0.2	4%	
Strategy-informed commissioning activity – Improved access to after-hours health services *NB: this activity is related to the first and was expected to be initiated in March 2020 and run into the following year.*	$2.6	49%	
After-hours disadvantaged services	$2.5	48%	✓
Total	**$5.3**	**100%**	

Note: $1.8m Innovation project funding listed in the 2019–20 Northern Queensland PHN Activity Work Plan is from carry over funding from the previous years.

Commissioned services

Table 52 presents a summary of the commissioned services within the case study site.

Table 52 – Commissioned services, 2019–20

Commissioned service name	Description	Commenced	Staffing model	Funding 2019–20
Telehealth Doctor NQ (provided by House Call Doctor)	A telehealth service that increased access to after-hours services, specifically for patients that live in rural, regional and remote areas within the PHN catchment. Also allows for face-to-face contact if necessary and in certain areas. Contract also allows the PHN to use the service to draft in additional GP resources if a GP is on leave or sick.	July 2019 but trialled initially. Full service in place from November 2019.	Made use of call centre and staff already providing services under the medical deputising service (House Call Doctor).	$1,600,000
Mulungu Aboriginal Corporation	Service sought to increase access to health services for Aboriginal & Torres Strait Islanders, increase primary care workforce training, improve coordination of GP and allied health services, and improve community awareness of these services to prevent potentially avoidable ED attendances.	July 2019	Supported primary care workforce development and the employment of staff to improve service access. This includes outreach services in rural and remote areas.	$154,000

Source: Northern Queensland Primary Health Network (2020a)

The new Telehealth Doctor NQ service is intended to provide options for patients who do not have access to primary care after hours. Although the service was rolled out across Northern Queensland PHN, the service primarily targeted rural, regional and remote areas such as Bowen, Mission Beach, Tully and Atherton Tablelands. For patients without access to the internet or necessary hardware, pharmacies have been provided with tablets by Northern Queensland PHN for patient use to access Telehealth Doctor NQ (Northern Queensland Primary Health Network, 2019b). Telehealth Doctor NQ uses a call centre in Brisbane, although with a dedicated number for Northern Queensland. The call handlers triage calls and divert to a local GP. The service is free to patients.

House Call Doctor, which was commissioned by the Northern Queensland PHN to operate Telehealth Doctor NQ, receives monthly block funding with cost controls from the PHN to provide patient services. The contract provides block funding and a fee-for-service basis linked to call volumes. House Call Doctor is not able to claim Medicare benefits when receiving PHN funding for delivering the same services. In instances where the provider is supporting clinical service delivery rather than providing direct clinical services to patients (e.g. providing cover in areas with a temporary GP shortage), House Call Doctor uses Medicare benefits for the purpose of providing comprehensive primary health care services and reported on item numbers that the service claimed and how they used the Medicare benefits to provide additional primary health services.

What impact has the program had?

The Telehealth Doctor NQ, also known as the Northern Queensland PHN telehealth service, is relatively new and has been fully in operation only since November 2019. The PHN recently commissioned House Call Doctor to deliver the service. The PHN saw the benefit of having a service provider that can flexibly respond to existing or specific needs that may arise within the region. For example, Northern Queensland PHN was able to use House Call Doctor to deploy a GP to Magnetic Island when the local GP was sick. House Call Doctor has a large workforce and the flexibility to respond quickly. The PHN has been satisfied with the services provided.

Although MDSs cannot be advertised, the telehealth service was advertised under the branding of the Northern Queensland PHN telehealth service. The service had been in operation for only 4 months before the new COVID-19 MBS telehealth items were introduced in early March 2020. The availability of telehealth items for all GPs has resulted in a complex mix and the differentiation between the PHN-funded service and mainstream services has become blurred. As a result, there appears to have been some discontent from local GPs about the advertising of the telehealth service as they saw it as undermining their practices (in a period when consultations reduced) and so the advertising of the PHN service was discontinued for the time being.

The activity data for the telehealth service is summarised in Table 53 below. The patient volumes for Telehealth Doctor NQ show the total reported data for the Cairns, Mackay and Townsville regions from November 2019 to June 2020 (Northern Queensland Primary Health Network, 2020b). This is not broken down into the areas covered by the case study.

We were unable to assess the Mulungu Aboriginal Corporation service as they had not completed a service provider survey and did not respond in time for interview. The quarterly monitoring report was provided by the PHN, but it did not include any patient volume or contact details.

Table 53 – Commissioned services measures and outputs

Commissioned service name	Measure	Volume
House Call Doctor (since 1 November 2019)	Number of individual/mobile telehealth consults	1827
	Number of patients without regular GP at time of booking	476
	Number of consults referred to hospital/ambulance	57
	Number of patient reports issued to regular GP via My Health Record and/or secure messaging	1485

Source: Northern Queensland Primary Health Network (2020b)

In the data that was available to the evaluation, there was a greater proportion of calls from the Mackay area, making up 56% of all consults. It was also clear from the data that many of

these calls were from patients without a regular GP. Data for the latest month of bookings (June 2020) showed that two-thirds of calls were from the Mackay area and 68% of those (69 calls) were from Bowen. Of these, around a third reported no regular GP. Around 10% of all consults were for people who identified as Aboriginal and Torres Strait Islander peoples. Few calls were captured from the Atherton or Mareeba area. The service provider noted that calls reduced during the COVID-19 period and the introduction of the new MBS items also complicated the picture.

There is clearly some demand for Telehealth Doctor NQ within Northern Queensland PHN, especially in the Mackay area. Unfortunately, the underlying drivers are unclear. Call volumes appeared to be higher in March but have since declined with the onset of COVID-19. Bowen appears to be generating high levels of demand, which the provider notes may be linked to week-long GP waiting times in the two clinics in the town. The provider notes that Bowen practices are actively referring patients to the telehealth service but also highlights the lack of awareness of the service, which has limited its take-up.

There were mixed views on the telehealth service throughout the three localities. A previous service was decommissioned due to concerns about unethical behaviour, and this appeared to have clouded the views of some stakeholders about commissioning another service of this nature. Some stakeholders were unaware of what type of service was operating in the region and whether it was the same previously discredited business.

There was also positive feedback on the telehealth service operations. The volumes appear to be high and the service provider indicated that 60% of calls were from the areas in Northern Queensland that are not covered by the mainstream service (Cairns and Townsville). Their view was that the service was experiencing high demand from the case study areas. However, other areas were still limited by a lack of awareness, particularly on the part of GPs and other service providers. In addition to raising awareness among providers, stakeholders felt there was also opportunity to increase health literacy among consumers ("*Patients have no idea what [an] emergency is.*" [Local Stakeholder]).

Some stakeholders and practices that were providing a full after-hours service were concerned that the Northern Queensland PHN-funded telehealth initiative could undermine their local after-hours arrangements. Some stakeholders were concerned they had not been consulted, and feared Northern Queensland PHN kept them the dark about what the organisation was commissioning.

Consultation also uncovered concerns about the about the appropriateness of telehealth for treating specific patient groups (including Aboriginal & Torres Strait Islander peoples) as some cohorts may be more comfortable with face-to-face care arrangements.

There were also very mixed reports from stakeholders on the extent of Northern Queensland PHN's engagement. In some cases, there was evidence of strong working relationships and engagement. However, some stakeholders commented that they have found it hard to communicate and engage with the PHN. For example, one provider stated that there was a 'telephone wall' between local providers and the PHN, lamenting they could only contact the PHN via email. This breakdown appears to have hindered relationships with primary care, affecting the distribution of information and general awareness of available services. In some cases, it was not a fact of not being involved in engagement activities, such as workshops or round tables, but that stakeholders felt that when they did participate, the PHN was not 'really listening'.

There was also a view that the PHN was very focused on GPs as representing primary care rather than looking more broadly at other aspects of primary care. The PHN strategic development work, which was conducted by an external consultant, included stakeholder engagement, but few respondents appeared to be aware of this activity and said they had not been involved in any of the stakeholder workshops or consultations held.

Further feedback and opportunities to improve the program

The after-hours services being commissioned are clearly of benefit to the community, but there does appear to be a desire for a more consistent dialogue with the wider community of stakeholders. Some stakeholders expressed positive views and exhibited stronger relationships with Northern Queensland PHN, however, this was not universal, leading to a lack of support for Northern Queensland PHN's approach to commissioning after-hours services. It is acknowledged by some stakeholders that because Northern Queensland PHN is spread across four different hospital and health service areas, it therefore faces a significant challenge that few other PHNs encounter. Northern Queensland PHN recognises that there is more work to do in developing consistent strategic relationships across their area.

Recruitment and retention of GPs and other staff in rural settings again presented in this case study. Northern Queensland PHN and others were engaging in a variety of ways to address this systemic issue. However, the general shortage of GPs meant that even those newly working in the area have enough work without resorting to the less desirable after-hours care.

The low level of patient demand, especially beyond 10 pm, left stakeholders questioning the sustainability of after-hours care beyond the ED. Some stakeholders stated that consumers have "adapted" to the limited after-hours options in areas such as Mareeba and Bowen while others reported a "relatively high" demand for primary care services during the sociable after-hours period from 5 pm to 10 pm, although this wasn't quantified.

The extent to which demand is affected by current availability or supply of after-hours care is unclear, especially when there was a general shortage of in-hours primary care. One stakeholder commented, "*If you want to fix the after-hours problem, you have to fix the in-hours problem first.*" [Local stakeholder] Although unsure it would be a cure, there was acceptance of the idea of supporting practices to extend their weekday and weekend hours and thus reduce some of the demand and access issues in these regions.

Stakeholders commented that it was hard to dissuade individuals from attending the ED during the after-hours period when they know they will have access to free, comprehensive care that includes pathology, radiology and imaging services that many after-hours clinics may not have onsite.

Other providers also expressed concerns about the quality of after-hours care and its perceived lack of patient continuity. The relationship with other service providers and GPs is an important element addressed by Northern Queensland PHN-provided services, but not always pursued by other service providers.

Opportunities to improve the program were identified as follows:

- There was a need to **develop more collaborative and strategic partnerships** between the acute and primary health care sectors. Stakeholders considered that there were opportunities for Northern Queensland PHN to be more proactive in facilitating strategic planning with respect to after-hours responses. Establishing a partnership of this nature may provide a forum for improved coordination, planning and more effective service delivery, and in time, provide opportunities to co-design and co-fund activities.
- The PHN After Hours Program **funding cycle and agreements need to be longer than one year.** This would assist greatly in planning, recruitment and assist in addressing employment and associated challenges.
- The issue relating to advertising and **promotion of services** appeared to be complex and needed clarification. This issue highlights a more fundamental tension for PHNs in finding ways to commission much-needed services that are not seen to be undermining existing service providers in an unfair way.
- There should be increased emphasis on supporting in-hours access to GP services. This will potentially lead to decreased demand for after-hours services and improved care.

Stakeholders consulted and survey responses

Table 54 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other
Local GP practices			3
Area health services			4
Clinical advisory panel member			1
Other primary care providers			1
Telehealth provider		2	
Hospital services			1
PHN	2		
Total	**2**	**2**	**10**

Table 55 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider survey (case study providers)	1
Commissioned service provider survey (other commissioned providers)	0

10 Northern Territory PHN

Case study scope and focus

The **Alice Springs** case study is a **geographically based case study** for the PHN After Hours Program evaluation with a specific focus on direct patient care (as opposed to system integration or capacity building).

What were the key observations from this case study?

What we learnt:

- **Prior to 2015, there were no after-hours primary care services available in Alice Springs**. Since then, a combination of the Northern Territory PHN After Hours Program funded clinics and expanded hours from one other clinic in the area has resulted in a significant improvement in access to after-hours primary health care services.
- Despite this, a **lack of bulk-billing general practices** in Alice Springs presents a significant barrier to access, even where practices provide after-hours services. This was identified is a key consideration in patients' choice to attend the ED at Alice Springs Hospital.
- There are opportunities to further **develop more collaborative and strategic partnerships** between the acute and primary health care sectors. Stakeholders considered that there were opportunities for Northern Territory PHN to be more proactive in facilitating strategic planning with respect to connecting primary and tertiary care services to enhance after-hours responses. Establishing partnerships of this nature may provide a forum to improve coordination, planning and more effective service delivery, and in time, provide opportunities for co-design and co-funded activities.
- The PHN After Hours Program **funding cycle and agreements need to be longer than one year.** This would assist greatly in planning, recruitment and retention of staff, as well as assist in addressing industrial relations challenges.

Locality overview

The Northern Territory PHN supports primary care services across the entirety of the Territory. Although the resident population is relatively small – estimated at 224,941 – it is spread across 1.3 million square km, equivalent to five times the geographic area of the United Kingdom (Northern Territory Primary Health Network, 2019b).

According to the MMM classification, the majority of the Northern Territory PHN by area falls within categories 6 and 7. However, 57% of the population live within the MMM category 2 region of Darwin and its surrounds.

The next most populous areas of Alice Springs, Katherine and their surrounds account for 18.4% of the population and fall within MMM category 6. The most remote category, MMM 7, covering most of the Northern Territory, is home to only 21% of the population. The Northern Territory PHN experiences a high turnover of residents, both seasonally and over longer durations, affecting both service demand and workforce supply, particularly in more remote locations.

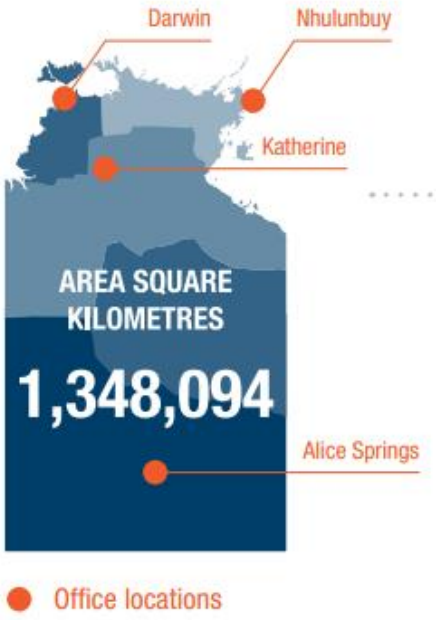

Figure 23 – Map of the Northern Territory PHN

Source: Department of Health (2015)

Territorians, particularly Aboriginal people, can experience challenges when accessing care across health service boundaries, particularly around language and cultural safety issues (Kelly et al., 2015). Health services in the Northern Territory PHN are delivered by a mix of Government services, private practices, ACCHS and other NGOs. Privately owned and operated services are more common in urban and regional areas, with core services in remote areas largely delivered by Northern Territory PHN Government clinics or by ACCHS.

Current after-hours health service provision in the Northern Territory PHN can be classified into six broad models (Northern Territory Primary Health Network, 2019b):

- GP practice after-hours services – fee-for-service or bulk-billing
- after-hours ACCHS regional clinics
- after-hours public hospital – ED
- after-hours services in remote clinics with outreach capability – Northern Territory PHN, Government and ACCHS
- after-hours medical retrieval
- Healthdirect after-hours telephone helplines
- After-hours GP telehealth (evolving).

The first two models operate predominantly in Darwin and, to a lesser extent, Alice Springs (the case study site) and Katherine. Remote medical clinics generally provide 24-hour coverage and are predominantly nurse-led with remote medical support. The nurse-led remote clinic models are likely to have a negative impact on assessments of after-hours access that rely on GP hours and ED attendance data (see below).

In comparison to the 31 PHNs in Australia, the Northern Territory PHN is ranked (Australian Bureau of Statistics, 2016a):

- **2nd** in terms of geographic size
- **30th** in terms of the total population supported.
- **1st** in terms of the proportion of Aboriginal and Torres Strait Islander peoples supported.

Table 56 compares the rate of total and after-hours GP attendances per 1,000 population in the case study area, the entire Northern Territory PHN, regional PHNs and the national PHN average. The case study areas have significantly lower rates for GP attendances, even compared with the entire Northern Territory PHN. Total attendances in the case study area

are 56% of those observed nationally, while after-hours attendances are only a quarter. ED presentations data are not available for the PHN.

Table 56 – Comparison of GP after-hours attendance rates

Service measure	GP attendances (crude rate, per 1,000)	
	Total attendances	After Hours attendances
Case study area (Alice Springs)	3,523	114
Northern Territory PHN	4,506	367
Regional PHN average	6147	269
National PHN average	6316	490

Source: Australian Institute of Health and Welfare (2020a)

In considering these data, it must be acknowledged that the unique Northern Territory PHN service setting may make comparison to other PHNs difficult. Further, the use of GP data may not best represent after-hours access and utilisation in the Northern Territory PHN, as:

- many remote medical clinics generally provide 24-hour coverage, which tends to be predominantly nurse-led.
- it does not take account of the GP workforce shortages, particularly in Katherine and Nhulunbuy, where there is no capacity for GPs to provide after-hours services on top of their existing workload. This is a general remote workforce issue as opposed to a specific after-hours program issue.

Alice Springs

Key population and health data relevant to the understanding of the case study:

- Alice Springs is the second-largest town in Northern Territory PHN, after Darwin, with an estimated population of over 29,000 people. This makes up 8.7 per cent of the Territory's population.
- Aboriginal Australians make up approximately 18.8% of the population of Alice Springs and 27.8% of the Northern Territory.
- Stakeholders considered the Aboriginal community in general are more likely to visit the ED for a primary health reason than to visit a GP.
- Alice Springs is designated MMM category 6 remote and Australian Statistical Geographical Classification – Remoteness Area 4 (ASGC-RA4) under the Australian Standard Geographical Classification.
- Index of Relative Socio-economic Advantage and Disadvantage for Alice Springs is 1015, (decile 9) (Australian Bureau of Statistics, 2016f).
- The Alice Springs Community Living Areas or Town Camps are an important part of the Northern Territory's Aboriginal and Torres Strait Islander community and are highly valued by their residents (Deloitte, 2017). The Alice Springs Town Camps provide a unique aspect to delivering primary health care services due to their high level of remoteness and patient cohort, which has historically experienced a high level of socio-economic disparity and health inequality. The 2016 census identified 961 people living in Alice Springs Town Camps (Australian Bureau of Statistics, 2016b).

Health services within the case study service setting/locality

After-hours health service provision in the Northern Territory PHN can be classified into six broad business models, As reported earlier, of these, the Alice Springs population was effectively supported by two:

- Extended or after-hours GP services – fee-for-service or bulk-billing
- the after-hours public hospital – ED.

Table 57 below outlines the services operating within the case study site.

Table 57 – Health services in the Alice Springs area

Type	Type, number and service parameters
Private GP practices	There are 26 GP clinics listed on Healthdirect.gov.au in the greater Alice Springs area. These include clinics in the Barkly, remote clinics operated by Central Australian Aboriginal Congress (Congress) and other ACCHS. Within the township of Alice Springs, there are three non-ACCHS practices (excluding headspace and the hospital pain clinic) and six Congress sites (including Amoonguna). Apart from Central Clinic (limited), only ACCHS provide bulk-billing services. Stakeholders generally considered the lack of a bulk-billing general practice in Alice Springs as a significant issue affecting primary care access.
Medical deputising services	None
Aboriginal Community Controlled Health Services (ACCHS)	Congress run a number of clinics in Alice Springs, providing culturally appropriate services for the social, emotional, cultural and physical health and wellbeing of Aboriginal people.
Pharmacies	There are four pharmacies listed on Healthdirect.gov.au in the greater Alice Springs area,
Public hospitals & EDs	Alice Springs Hospital with a 24 hour ED.
Private Hospitals & EDs	None
Nurse and GP telephone helplines	Healthdirect Australia
Other	None

What options are available to access after hours?

Stakeholders reported that prior to 2015, Alice Springs Hospital ED was the only source of health care services after hours. This first changed with the addition of the Congress Clinic, co-located at the Alice Springs Hospital (see further detail below), which was commissioned by the Northern Territory PHN After Hours Program.

After this, one other GP clinic (Central Clinic) gradually extended its hours in the after-hours period. It currently operates 8 am to 8 pm Monday to Friday, and 8 am to 4 pm on Saturday, Sunday and public holidays. Stakeholders believed Central Clinic's move to extend its hours was a commercial decision, and not directly linked to the PHN After Hours Program or changes to MBS or PIP.

Most recently, Northern Territory PHN commissioned the Dr in the House service (see below) to provide after-hours primary care.

Northern Territory PHN approach

Northern Territory PHN conducted an initial needs assessment in 2015. The needs assessment included consultations with 50 organisations and 111 individuals, including GPs, pharmacists, residential aged care, hospital and health service districts, and ACCHS.

Consultations identified a range of gaps in after-hours services as well as identifying local solutions. The needs assessment was also supported by a comprehensive service review, which identified all primary health care services and opening hours across the jurisdiction. These planning activities led to the development of the key priority areas for the after-hours program.

Northern Territory PHN advised that it established a formal procurement process to select and commission after-hours service providers. The process allowed the PHN to negotiate on a case-by-case basis, refining and defining the provider's proposed service delivery model, to address the issues identified by their needs assessment and align with the program aims and objectives. Additionally, one service provider reported that they approached the PHN with a service design proposal and sought funding support to address an identified need in the community. This was not part of the earlier procurement process but was commissioned by Northern Territory PHN as a trial project subsequent to the initial tender.

In addition to establishing a formal procurement process, the PHN commissioned the Northern Territory PHN after-hours primary health care Innovation Grants program. Commencing in 2016, the PHN invited eligible organisations to apply for grants to fund innovative pilot projects that aim to increase the accessibility and effectiveness of after-hours primary health care in the Northern Territory PHN. Pilot projects were to target priority areas as follows:

- Innovative approaches to increasing access to after-hours general practice/primary health care in urban, rural and remote areas
- Aboriginal health workforce
- General Practitioner support for frontline health professionals
- After-hours access to allied health professionals
- After-hours support for Residential Aged Care Facilities
- Increasing access to pharmacy services after-hours

Northern Territory PHN performed a selective review and update of its needs assessment in 2019. The selective review refreshed statistics and identified new population health areas to be targeted, adjusting priorities and options where appropriate. The Alcohol and Other Drugs, Psychosocial and After Hours needs assessments were comprehensively reviewed as part of the 2019 review.

The 2019 review of the After Hours Needs Assessment incorporated consultation and learnings from the development and commissioning of services and changes identified in the service environment.

Although the 2019 review considered the lessons learnt in service commissioning and assessed the changing service environment, the key findings and priority areas identified in the 2015 review remained relatively unchanged.

Total annual funding for the After Hours Program for the past two financial years is presented in Table 58 below. On a population basis, the Northern Territory PHN receives a greater share of funding than most PHNs, recognising that service delivery costs in remote locations are significantly higher than in non-remote settings.

Table 58 – Summary of Northern Territory PHN After Hours funding

Financial year	Total AH program funding (PHN)	AH funding per 1,000 population (PHN)	All PHNS AH funding per 1,000 population	PHN ranking (AH funding per 1,000 population)
2019–20	$3,325,559	$14,784	$3,056	2nd
2018–19	$3,356,559	$14,922	$2,867	2nd

Northern Territory PHN developed six key priorities areas as part of its after-hours primary health care response, summarised as follows (Northern Territory Primary Health Network, 2019b):

- Increasing access to after-hours general practice/primary health care in urban, rural and remote areas.
- Increasing the role of Aboriginal Liaison Officers, Aboriginal Health Workers and Aboriginal Health Practitioners in the delivery of after-hours general practice/primary health care in urban, rural and remote regions.

- Increasing access to GPs for clinical support in person or via telephone and video conferencing.
- After-hours access to allied health professionals.
- After-hours support for RACFs.
- Increasing access to pharmacy services after hours.

This is reflected in the Activity Work Plan (Northern Territory Primary Health Network, 2019a):

Table 59 – Northern Territory PHN-funded activities from Activity Work Plan

Priority area	Funding allocated 2019–20		Represented in case study
	$'m	%	
After Hours in Regional Hubs	$1.8	44%	✓
After Hours in Remote Communities	$0.7	17%	
After-hours hospital into primary health care pathway	$1.0	23%	✓
Northern Territory PHN Health Pathways expansion to improve safety and quality of after-hours care	$0.3	6%	
Northern Territory Supporting Health Care Home Model Implementation Strategy	$0.1	-	
Northern Territory PHN Health Care System Digital and Innovation Readiness	$0.3	6%	
Total	$4.2	100%	
Comprising:			
2019–20 funding allocation	$3.3m		
Funds carried forward from prior periods	$0.9m		
Total	**$4.2m**	**100%**	

Service design

The Northern Territory PHN developed a response, summarised in the program logic diagram in Figure 24, to commission activities at a "direct service delivery" level, as well as at a "system integration level", supported by capacity-building efforts targeted towards both the consumer and the provider.

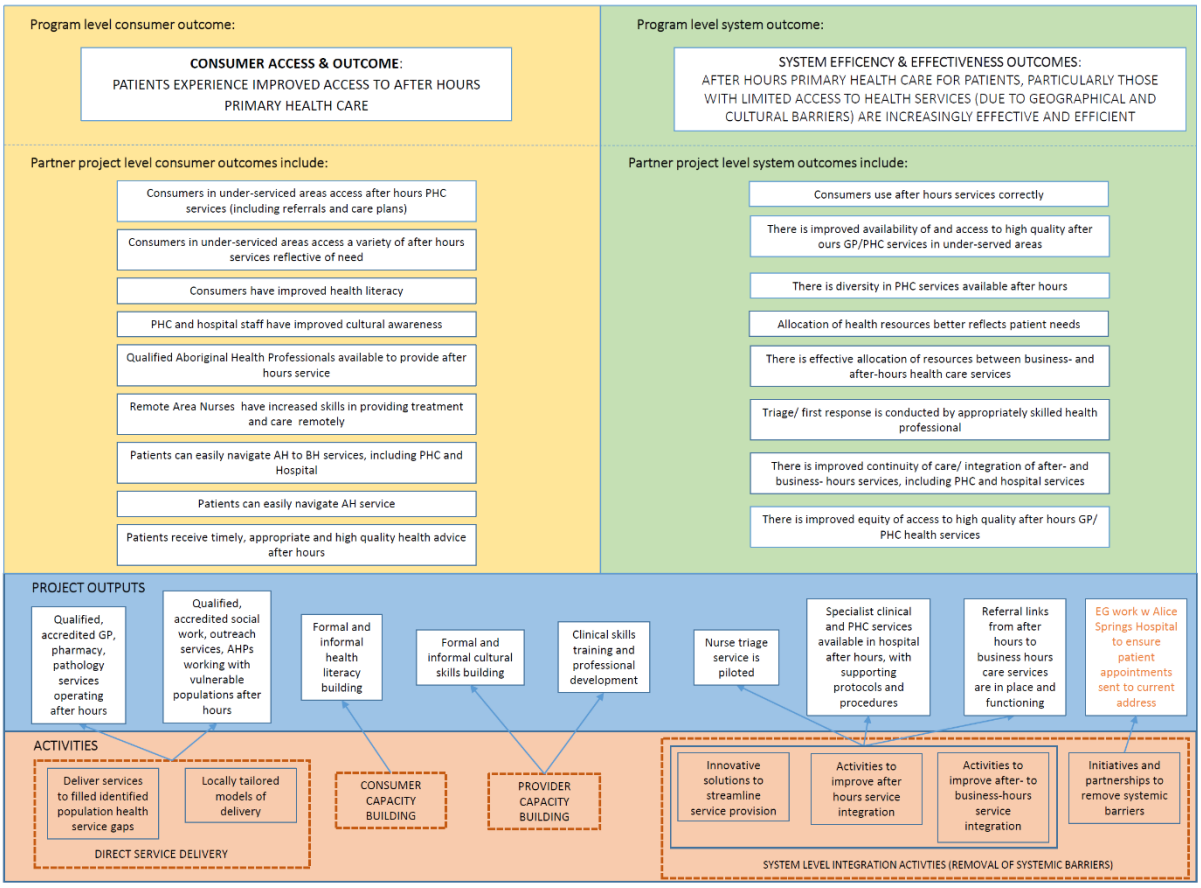

Figure 24 – Northern Territory PHN after-hours program logic

In respect of the case study site, evaluation activities focused on the "direct service delivery" commissioned services. Table 60 presents a summary of the commissioned services within the case study site.

Table 60 – Commissioned services, 2019–20

Commissioned service name	Description
Central Australian Aboriginal Congress After Hours Clinic	After-hours GP Clinic co-located at Alice Springs Hospital, operating with the aim of improving access to after-hours primary health care for residents and visitors of Alice Springs and easing the burden on acute care hospital services. The key features of the model were: • Employment of 0.8 receptionist • Practice Manager and GP Coordinator • No scheduled appointments provided (with the exception of a case-by-case basis at the request of a GP) • Category 4 and 5 patients prioritised based on Australian Triage Classification System • Average of 12 GP consultations per day desired • Bulk-billing service
Central Australia Health Service, After Hours Social Work	After-hours Access to Social Work Service at Alice Springs Hospital with the aim of providing social work services to the most vulnerable patients accessing the Alice Springs Hospital. Key objectives were to: • Ensure patients identified in the after-hours period as Priority 1 referrals were reviewed, assessed and had a treatment plan generated to ensure that patients are appropriately referred to support services in a timely manner • Reduce social admission to Alice Springs Hospital.

Commissioned service name	Description
Central Australia Health Service, After Hours Pharmacy	The aim of the project was to improve access to Alice Springs Hospital Pharmacy by extending business hours on weekends and public holidays through the funding of additional personnel expenses. The project had four objectives: • Increase Alice Springs Hospital Pharmacy weekend service to 9 am to 2 pm every Saturday, Sunday and 10 public holidays • Support clinicians by dispensing discharge and non-imprest medicines at Alice Springs Hospital Pharmacy during extended hours • Provide patients who are discharged during extended hours with appropriate medicines and information from a pharmacist • Provide receiving care clinicians with pharmacist-led discharge summaries for 'high-risk' patients (those prescribed 5 or more medicines) within 48 hours of discharge medicines being dispensed
After-hours home GP visits (Dr in the House)	Bulk-billed home doctor service providing urgent after-hours care every Monday, Thursday, Friday, Saturday and Sunday. With the aim to provide improved access to after-hours care, and reduce non-urgent admissions to the ED.

The intended primary impacts of the above commissioned services are summarised below:

- Improve access to primary care in the after-hours period – **2 of 4 services**: Central Australian Aboriginal Congress After Hours Clinic, and After-hours home GP visits (Dr in the House).
- Reducing non-urgent ED presentations – **2 of 4 services**: Central Australian Aboriginal Congress After Hours Clinic, and After-hours home GP visits (Dr in the House).
- Reducing admissions or re-admissions to the hospital over the weekend – **2 of 4 services**: Central Australia Health Service, After Hours Social Work, and Central Australia Health Service, After Hours Pharmacy.
- Facilitating hospital discharge over the weekend – **1 of 4 services**: Central Australia Health Service, After Hours Pharmacy.

Challenges for providing access to after hours in this locality

Northern Territory PHN's needs assessment and the evaluation have identified the following issues relevant to planning and providing after-hours access in the township of Alice Springs:

- There is a **lack of bulk-billing general practices** in Alice Springs, presenting a significant barrier to access, even if practices do provide after-hours services. This is seen as a driver of patients presenting to ED at Alice Springs Hospital for primary care.
- The **general practice workforce in Alice Springs is often transient** and heavily reliant on locums and overseas-trained doctors. This provides challenges of recruitment and retention.
- **Workplace agreements and conditions.** Existing awards and enterprise agreements limit the ability of the workforce to work extended hours. The commissioned services at Alice Springs Hospital citied "industrial relations" issues as a key barrier to extended hours.
- **The disease profile in Alice Springs (and the Northern Territory PHN)** differs from other locations. GPs with experience in this context are scarce.
- **Service users from Town Camps or from the surrounding** communities have historically used the ED as their preferred source of health care.
- **There is a higher proportion of the population who speak English poorly** or not at all, which introduces significant health literacy challenges for all sectors, not just primary health care.
- There is a lack of service utilisation data to inform service planning and design.

What impact has the program had?

Stakeholders believed all commissioned services had successfully implemented their intended service design and were currently meeting their individual service objectives.

All commissioned services provided activity data to the PHN, which is summarised in Table 61 below.

Table 61 – Outputs from commissioned activities

Commissioned service name	Measure	Volume
Central Australian Aboriginal Congress After Hours Clinic	Clinic encounters	1,653 encounters in 6-month period to 31 December 2019. **9.2 encounters per day**
Central Australia Health Service, After Hours Social Work	Service users' attendances (Saturday and Sunday)	240 attendances in 6-month period to 31 December 2019. **4.6 attendances per day.**
Central Australia Health Service, After Hours Pharmacy	Attendances (Saturdays, Sundays and public holidays)	1,969 attendances in 6-month period to 31 December 2019. **36.5 attendances per day**
After-hours home GP visits (Dr in the House)	Attendances in the home	215 (2-month period to 15 December 2019) **3.6 attendances per day**

A lack of impact and outcome data prevented an objective assessment of program impact; however, stakeholders made the following observations:

- There has been significant improvement in the availability of after-hours primary health care services in the past five years.
- The Alice Springs Hospital reported that over the past three years there has been a reduction in category 4 and 5 presentations.
- The current balance of services (in-home, after-hours GP clinics, and the ED) appeared to be meeting consumer demand, with each of the services complementing the other. Consumer and community sentiment regarding the availability of GP services and primary health care access, both in and out of hours, was much improved.
- While each of the commissioned services was meeting "a need", questions remained for some stakeholders whether the programs are meeting the right needs and focused on the most appropriate service delivery outcomes.

Given these comments, some stakeholders questioned whether some elements were still required, or could be funded from other sources. It was suggested that, subject to formal needs assessment, after-hours funding currently directed to services within Alice Springs could be redirected to after-hours activity in remote communities. That said, it must be acknowledged that services, like the after-hours pharmacy service, have a focus on allowing patients to return home to remote communities sooner (rather than staying in hospital) through access to medication preventing a return to hospital. This illustrates the challenging dynamic and interplay of services in remote locations.

Improving the program

Opportunities to improve the program were identified as follows:

- This is a need to further **develop collaborative and strategic partnerships** between the acute and primary health care sectors. Stakeholders considered that there were ongoing opportunities for Northern Territory PHN to be more proactive in facilitating strategic planning with respect to after-hours responses. Establishing a partnership of this nature

may provide a forum for improved coordination, planning and more effective service delivery, and in time, provide opportunities to co-design and co-fund activities. The Northern Territory PHN is continuing to pursue this outcome.

- The PHN After Hours Program **funding cycle and agreements need to be longer than 1 year.** Would assist greatly in planning, recruitment and help overcome industrial relations challenges
- Some stakeholders suggested the Northern Territory PHN After Hours Program should continue to **develop a program of pilots and trials,** through seed funding to test alternative approaches and foster innovation (noting that the Northern Territory PHN did in fact fund a program of pilots and trials through the Innovation Grants (refer earlier) and these trials informed the extension of successful pilot activities based on outcomes).
- Develop an increased focus on measuring and reporting program impact and outcomes.

Stakeholders consulted and survey responses

Table 62 – Stakeholders interviewed

Stakeholders by organisation	Interviewees		
	PHN	Commissioned services	Other
Northern Territory PHN	5		
Central Australia Health Service (Executive)			2
Alice Springs Hospital - Pharmacy		1	
Alice Springs Hospital – Social work		1	
Central Australian Aboriginal Congress		1	
Dr in the House		2	
Consumer (PHN Community Council)			1
Total	**5**	**5**	**3**

Table 63 – Survey responses received

Stakeholders by organisation	Number
PHN survey	1
Commissioned service provider survey (case study providers)	1
Commissioned service provider survey (other commissioned providers)	0

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