AFTER HOURS PRIMARY HEALTH CARE DIAGNOSTICS AND PRIORITISATION PROJECT

Final Report

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Jaffe Consulting Pty Ltd

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1. INTRODUCTION

The disbanding of the Medicare Locals (MLs) and the rolling out of Primary Health Networks (PHNs) in July 2015 have resulted in a change in funding structure for provision of services, with PHNs acting as purchasers and commissioners of services, rather than being responsible for service delivery. From 2016-17, PHNs have had greater flexibility to commission programme specific services, having completed needs assessments for their regions and associated population health planning. PHNs are funded to address gaps in after-hours service provision and improve service integration within their PHN region (EMPHN, 2016).

After hours primary health care in Australia is defined as 'accessible and effective primary health care for people whose health condition cannot wait for treatment until regular primary health care services are next available. After hours primary health care is not intended to be a substitute for primary health care that could otherwise occur in-hours'.

The after hours period is broken down into sociable and unsociable hours:

- Sociable hours are defined as: Weeknights – 6pm to 11pm.
- Unsociable hours are defined as: Weeknights – 11pm to 8am; Saturdays – before 8am and after 12pm; All day Sundays and public holidays (Ernst and Young, 2016).

After hours primary care has the potential to improve consumer access to services and reduce the burden on hospital emergency departments. Examples of how this could be achieved include:

- *Practice-based services* – Provision of after hours primary care services within general practices that are open extended hours.
- *Co-located GP services* – Provision of after hours GP services co-located on hospital grounds.
- *GP cooperatives* – Cooperative arrangements are general practices working together to provide care to patients outside the normal opening hours of their practices, often via after hours cover roster arrangements.
- *Minor injury and walk-in centres* – Nurse-led centres for treatment and advice on minor health issues.
- *Medical deputising services* (MDS) – Provision of urgent after hours primary care at a patients home or in an aged care facility by a GP on behalf of another GP. The Medical Deputising Service is often
  delivered by commercial companies which employ a roster of GPs.
- *After hours home visiting services* – Provision of urgent and non-urgent after hours primary health care to patients in their home and in aged care facilities in a non-deputised capacity by a doctor (but not necessarily a GP).
- *Telephone triage and advice services* – 24 hour, seven days per week telephone triage and advice delivered by a medical professional (nurse or GP), intended for people whose health

condition cannot wait for treatment until regular general practice opening hours or do not know where to access after- hours care.

- *Web-based* – Online access to health care information, including symptom checker, details about nearest after hours clinics and pharmacies, and information on the 24/7 telephone triage and after hours GP helpline services.
- *Emergency departments* – Provision of emergency health care in the after hours period. In some rural/remote areas where sole GPs are unable to provide after hours services in the community, this is the only source of after hours service provision, with the GP fulfilling the visiting medical officer (VMO) responsibilities in the after hours period at the region's hospital.
- *Royal Flying Doctors Service (RFDS)* – Provision of urgent medical attention 24 hours a day, seven days per week to remote and very remote communities. RFDS also provides 24-hour telehealth services with a medical chest) available for emergency medications (Ernst and Young, 2016).

PHNs have been tasked to implement innovative and locally tailored solution for after hours services based on community need. As such, PHNs receive after hours flexible funding to improve access to after hours services in their region, and to ensure patients receive the right care, delivered by the right provider, in the right place and at the right time. The funding which PHNs receive for after hours aims to enable them to work with local after hours stakeholders to plan, coordinate, and support population-based after hours health services. PHNs are required to focus on addressing gaps in after hours service provision, targeting solutions for 'at risk' populations, and improving service integration, particularly where gaps exist due to a lack of access to general practices registered for the After Hours Practice Incentive Programme (PIP) (Ernst and Young, 2016).

2. The After hours Primary Health Care Diagnostics and Prioritization Project

In May 2017, Jaffe Consulting Pty Ltd was engaged to:

1. Conduct a rapid review of after hours primary health care access issues using a systematic approach and sound sampling methodology to obtain a view of the after hours catchment needs and subsequently identify the top five (5) AH Primary Health Care issues across the EMPHN catchment.
2. Determine the impact that regional characteristics may have on the after hours needs of the community including: Identifying services available, utilisation of services, access inhibitors and health literacy concerns.
3. Identify factors impacting utilisation of services including workforce capacity of GP medical services, medical deputising services (MDS) and Emergency Departments' (ED) capacity to service regional after-hours needs.

4. Ensure that the information gathered is from a representative sample of stakeholders including general practices, pharmacies, residential aged care facilities, MDS, hospital networks and groups for whom access to primary care is more likely to be an issue. *See Appendix 1: Project Brief*

The EMPHN Activity WorkPlan 2016-2018 includes the After Hours Primary Care Funding Annual Plan 2016-2017 which provides:

- The strategic vision of each PHN for achieving the After Hours key objectives.
- A description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.
- The indicative Budget for After Hours Primary Care funding stream for 2016-2017.

Planning is expected to identify local priorities which in turn will inform and guide the activities nominated for action in the 2016-2018 Annual Plan, including opportunities for new models of care within the primary care system, such as the patient-centred care models and acute care collaborations. Consideration should be given to how the PHN plans to work together and potentially combine resources and co-design, with other private and public organisations to implement innovative service delivery and models of care. Development of care pathways will be paramount to streamlining patient care and improving the quality of care and health outcomes. .

The strategic vision for after hours funding is to achieve the key objectives of:

- increasing the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to Health Services; and
- improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care.

In 2016-17 and onwards, EMPHN is required to:

- Implement innovative and locally-tailored solutions for after-hours services, based on community need; and
- Work to address gaps in after-hours service provision (EMPHN, 2016)**.**

Internal structures

The EMPHN organisational structure includes programs that support and develop primary care practitioners, and that support primary care improvement and integration. In addition to the formal governance structure, EMPHN staff work across teams within specialty area streams such as Indigenous Health, Aged Care, Refugee Health and Mental Health. EMPHN staff also work across teams to participate in improvement and innovation initiatives. At present the activities proposed by EMPHN to be undertaken with after hours funding in the period 2016-18 address:

1. Limited access to GPs and other primary health care services in the after-hours period

2. Limited RACF access to GPs and other primary health care services in the after-hours period
3. Increase quality and capacity of after-hours primary health care services
4. Increased community awareness of after hours services and options
5. Culturally safe and accessible primary health care services for Aboriginal and Torres Strait Islander, and CALD and Refugee people
6. Increased access to mental health services in the after hours period – *see Appendix 2: Activity Workplan Template* (EMPHN, 2016).

2.1 METHODOLOGY

The following activities were undertaken:

- **Project management** included project oversight by an EMPHN project steering committee and nominated contract manager. The contract manager provided relevant data, resources and the contact details of key informants to be consulted – *see Appendix 1: Consultation Protocol.*
- **Desktop review** included relevant demographic and health service utilisation data provided by the EMPHN; review of after-hours healthcare initiatives undertaken by PHNs across Australia; and review of internet sourced publications that could inform the delivery of after-hours healthcare in the EMPHN catchment.
- **Consultations** were conducted with key informants to build on information gained from previous consultations conducted by the EMPHN. The key informants presented their perspective on after hours primary healthcare including local context issues affecting after hours service provision, community needs and gaps; and workforce issues impact after hours healthcare service delivery. A brief discussion paper was prepared and distributed to key informants, providing the context for the consultations. Consultations included a group interview with the CAC and two forums targeting GPs, MDSs and Pharmacists; as well as individual consultations with key stakeholders in person or by phone – *see Appendix 3: Consultation Protocol*
- **Workshop on key findings** was facilitated by the consultants based on the draft report distributed to the project steering committee prior to the workshop.

2.2 PROJECT LIMITATIONS

The project was considerably limited by the short timeframe within which to complete tasks, particularly to consult key stakeholders, many of whom were unavailable within the project time frame. Other limitations which are not specific to this project relate to gaps in current and detailed data sets specific to the catchment and after-hours healthcare services.

3. WHAT WE KNOW ABOUT THE CATCHMENT

Eastern Melbourne PHN (EMPHN) was formed on 1 July 2015, incorporating the catchments and drawing on the resources and experience of three former Medicare Locals (ML): Eastern Melbourne ML, Inner East

Melbourne ML, and part of Northern Melbourne ML. The EMPHN catchment comprises the whole of 10 Local Government Areas (LGAs): Banyule, Boroondara, Knox, Manningham, Maroondah, Monash, Nillumbik, Whitehorse, Whittlesea, and Yarra Ranges. The catchment also includes a proportion of two rural and relatively less populous LGAs of Mitchell and Murrindindi, amounting to 34.7% and 27.4% of their respective populations. The total population of the EMPHN catchment stands at approximately 1.5 million people in 2015, up from 1.32 million people in 2011, as shown in the following table. The EMPHN catchment is one of considerable diversity, encompassing rural and semi-rural areas, new high-growth suburbs, and older established suburbs.

3.1 Age Distribution

Table 1 below indicates that approximately a quarter of the population of Victoria resides in the EMPHN area. The catchment has an increasingly ageing profile, particularly in the inner metropolitan LGAs but with a lower percentage than Victoria as a whole. There are also larger proportions of young people in the areas of Nillumbik, Whittlesea and the Yarra Ranges and this is higher than in Victoria as a whole. Whittlesea and Mitchell are projected to be major growth areas between 2011 and 2021.

TABLE 1 - POPULATION AND AGE DISTRIBUTION

Local Government Areas	Estimated Residential Population 2015	Projected per annum population change 2011-2021	Number of people aged under 15 year as percentage of the population	Number of people aged over 65 years as percentage of the population
Banyule	126,232	1.21%	16.7%	14.9%
Boroondara	174,787	1.16%	15.9%	13.6%
Knox	155,681	1.00%	17.8%	15.1%
Manningham	119,442	1.67%	15.3%	18.0%
Maroondah	112,310	1.00%	17.4%	14.1%
Mitchell *	39,143	4.14%	na	na
Monash	187,286	0.75%	14.1%	16.1%
Murrindindi *	13,595	0.96%	na	na
Nillumbik	62,202	0.17%	20.2%	9.2%
Whitehorse	165,557	0.68%	15.8%	15.9%
Whittlesea	195,397	3.52%	16.5%	8.9%
Yarra Ranges	150,661	0.72%	19.2%	12.0%
Total estimated Population	1,502,293			
Victoria (estimate 2014)	5,739,341		14.2%	19.2%
Approximate Percentage of Population of Victoria	26%			

**Data is not available for these areas as only a proportion reside within the EMPHN catchment area - Source: ABS 2011*

3.2 Population Diversity

Table 2 below shows that over 5,000 people identify as Indigenous within the catchment, particularly in the Whittlesea, Yarra Ranges, Banyule and Knox LGAs.

Higher percentages of people born overseas are found in Monash, Manningham, Whitehorse and Whittlesea. These areas also have a higher percentage of those people born overseas who have poor English proficiency. Higher numbers of overseas immigrant arrivals are found in Boroondara, Monash, Whitehorse and Whittlesea. Humanitarian arrivals are mainly concentrated in Maroondah, Whittlesea and the Yarra Ranges.

TABLE 2 - POPULATION DIVERSITY

Local Government Areas	Number of indigenous peoples	% people born overseas	% people born overseas with POOR English proficiency	Overseas immigrant arrivals per year (2013)	# Humanitarian arrivals 2013-14
Banyule	619	26.1%	2.7%	441	20
Boroondara	225	32.3%	3.1%	1,169	0
Knox	543	31.0%	2.8%	528	21
Manningham	158	40.0%	6.0%	757	30
Maroondah	403	24.4%	2.3%	536	246
Monash	340	49.1%	6.8%	2,069	4
Nillumbik	231	18.0%	0.6%	51	0
Whitehorse	315	37.6%	5.5%	1,657	20
Whittlesea	1243	36.9%	7.0%	1,152	111
Yarra Ranges	950	20.5%	0.7%	204	102
Total	5027				

Source: ABS 2011

3.3 Older Persons

In the EMPHN catchment between 21.1% and 30.9% of people aged 75 and over living alone in their own home across the ten LGAs, with high numbers in Whitehorse, Boroondara and Monash. As well between 12.7% and 21.3% of people aged 75 and over were living in a residential care facility, as shown in the table below, particularly in Boroondara and Whitehorse.

TABLE 3 - PEOPLE OLDER THAN 75 LIVING ALONE OR IN A RESIDENTIAL CARE FACILITY

Local Government Areas	Number of people aged 75+ (2011)	Number of people aged 75+ and living alone in their own home (HCFMD)	% of people Aged 75+ and living alone	Number of people aged 75+ and living in a residential care facility (NPDD)	% of people Aged 75+ and living in a residential care facility (NPDD)
Banyule	9,161	2,654	29.0%	1,517	16.6%
Boroondara	12,418	3,830	30.8%	2,257	18.2%
Knox	8,341	2,317	27.8%	1,493	17.9%
Manningham	8,575	2,139	24.9%	1,329	15.5%
Maroondah	7,538	2,329	30.9%	1,602	21.3%
Monash *	14,236	3,379	23.7%	na	0.0%
Nillumbik	2,033	502	24.7%	309	15.2%
Whitehorse	13,825	4,348	31.5%	1,917	13.9%
Whittlesea	7,029	1,485	21.1%	1,172	16.7%
Yarra Ranges	7,171	2,055	28.7%	909	12.7%
Total EMPHN Population	90,327	25,038	27.7%	12,505	13.8%

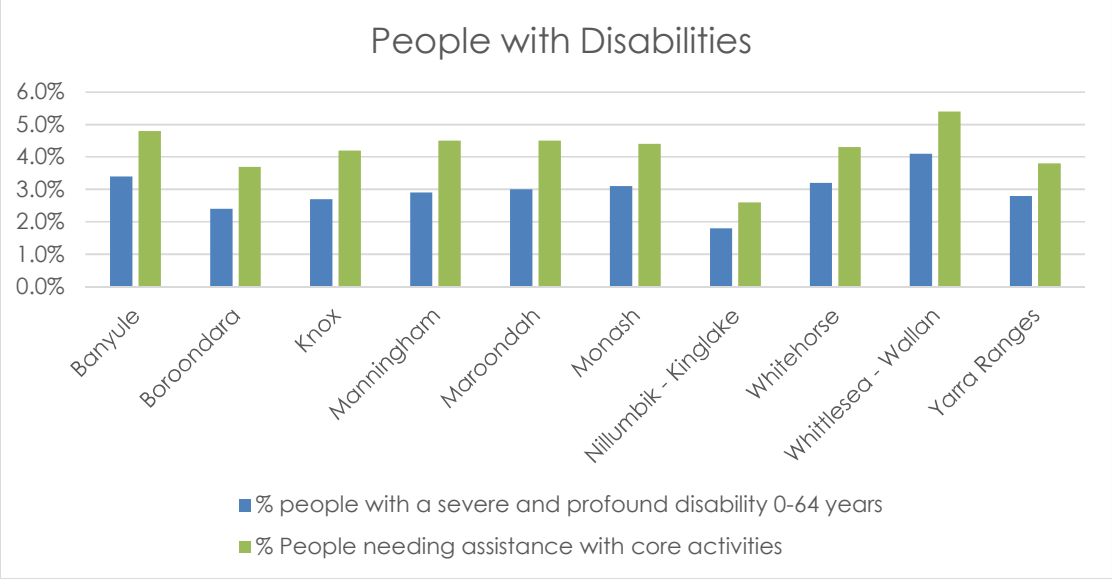
Source: ABS 2011

*Please note the figure provided by EMPHN for number of people aged over 75 in a residential care facility for Monash was 22,020 which do not tally with the population of only 14,236. Consequently this figure was not included in the analysis.

3.4 PEOPLE WITH A DISABILITIES

Across the catchment, Whittlesea has the highest percentage of residents with a Severe and Profound disability and well as people needing assistance with core activities, as shown in the chart below.

FIGURE 1 – PEOPLE WITH A DISABILITIES



Source: EMPHN 2017

3.5 SEIFA

Socio-Economic Indexes for Areas (SEIFA) is a product developed by the ABS that ranks areas in Australia according to relative socio-economic advantage and disadvantage. The ABS broadly defines relative socio-economic advantage and disadvantage in terms of people's access to material and social resources, and their ability to participate in society. Table 4 below includes the Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) for the ten LGA's within the EMPHN. SEIFA rankings can be used for research into the relationship between socio-economic disadvantage and various health and educational outcomes. Higher numbers indicate greater advantage and lower numbers indicate greater disadvantage.

In EMPHN Whittlesea has the lowest SEIFA score overall but the more detailed analysis at a SA1 level, which is the smallest level of ABS analysis, indicates that areas within other LGA's also experience higher levels of disadvantage. Whittlesea has over half of their population living in areas with a SEIFA less than 1000 but Maroondah and the Yarra Ranges also have approximately 30% of their population living in areas with a SEIFA less than 1000 – *see Table 4 below.*

TABLE 4 – SEIFA (SOCIO-ECONOMIC INDEXES FOR AREAS)

Local Government Areas	SEIFA relative socio-economic Advantage/Disadvantage scores (IRSAD), 2011	Minimum SA1 Score	Maximum SA1 Score	% of people living in areas where SEIFA <1000
Banyule	1044	773	1175	19.1%
Boroondara	1107	953	1205	1.2%
Knox	1046	754	1188	21.8%
Manningham	1136	970	1189	1.0%
Maroondah	1034	804	1187	29.9%
Monash	1051	867	1187	13.6%
Nillumbik	1094	935	1175	4.6%
Whitehorse	1057	773	1167	7.3%
Whittlesea	987	816	1142	51.8%
Yarra Ranges	1011	826	1161	30.6%
EMPHN	1053	754	1205	19.5%
Victoria		488	1205	41.0%

Source: ABS 2011

3.6 Income and Welfare support

Table 5 below has information on income levels and welfare support in the ten LGA's with the average for the entire EMPHN. It can be seen that Whitehorse has the highest percentage of low income households; Banyule has the highest percentage of disability support pensioners, people receiving unemployment benefits and income welfare dependent families with children, despite having a relatively high SEIFA; and Yarra Ranges has the highest percentage of female sole parent pensioners

TABLE 5 - INCOME AND WELFARE SUPPORT

Local Government Areas	Households with income <$650 per week (%)	Total Disability support pensioners (%)	Female sole parent pensioners (%)	People receiving an unemployment benefit (%)	Low income, welfare-dependent families with children (%)
Banyule	26.3%	5.4%	3.8%	3.5%	8.3%
Boroondara	20.0%	2.3%	1.0%	1.5%	3.1%
Knox	23.0%	4.3%	4.0%	3.0%	6.8%
Manningham	23.3%	2.1%	1.2%	1.3%	2.8%
Maroondah	26.5%	3.7%	3.6%	2.6%	6.3%
Monash	27.5%	3.5%	1.8%	2.3%	5.0%
Nillumbik	14.7%	3.1%	3.2%	2.4%	7.2%
Whitehorse	28.2%	3.4%	1.9%	2.1%	4.7%
Whittlesea	27.5%	3.5%	3.8%	2.4%	6.8%
Yarra Ranges	25.9%	4.5%	4.7%	2.8%	7.3%
EMPHN	24.2%	3.7%	3.1%	2.5%	6.0%

Source: ABS 2011

3.7 HOUSING AND HOMELESSNESS

Access to housing is an important aspect of health. Whittlesea has the highest percentage of households experiencing mortgage stress. Higher numbers of homeless people reside in Monash and Whitehorse than other areas of the EMPHN. Banyule has the highest percentage of social housing in the EMPHN area as shown in the following table.

TABLE 6 - HOUSING

Local Government Areas	Percentage of low income households spending more than 30% of household income on mortgage payments, 2012	Total number of homeless people, 2011	Social housing stock as percentage of total dwellings, 2012
Banyule	7.6%	461	5.0%
Boroondara	6.6%	380	1.5%
Knox	10.4%	246	2.4%
Manningham	10.6%	209	0.8%
Maroondah	8.5%	428	3.2%
Monash	11.3%	803	2.3%
Nillumbik	7.4%	82	0.8%
Whitehorse	9.0%	749	2.6%
Whittlesea	15.4%	476	1.9%
Yarra Ranges	11.3%	335	1.4%
EMPHN	9.9%	4169	2.2%

Source: ABS 2011

The ABS uses data collected in the Census and derives estimates of the prevalence of homelessness, and the characteristics and living arrangements of those likely to be homeless, on Census night. Homelessness is defined as when a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations

There are estimated to be 22,727 people who are likely to be homeless within Victoria and 18.2% of these reside within the EMPHN catchment. The table below identifies the numbers of Homeless Persons within each LGA.

TABLE 7 - HOMELESS PERSONS WITHIN THE EMPHN CATCHMENT

LGA	No. of Homeless Persons	% within Catchment
Banyule	463	11.2%
Boroondara	382	9.2%
Knox	249	6.0%
Manningham	205	4.9%
Maroondah	423	10.2%
Monash	793	19.1%
Nillumbik	84	2.0%
Whitehorse	739	17.8%
Whittlesea	472	11.4%
Yarra Ranges	337	8.1%
EMPHN	4147	100.0%
Victoria	22727	18.2%

Source: Census of Population and Housing: Estimating homelessness, 2011

The suburbs within EMPHN that have the highest numbers of homeless are identified in the table below. These suburbs have over 100 Homeless Persons and comprise 37% of Homeless persons in the catchment.

TABLE 8 - HOMELESS PERSONS GREATER THAN 100 IN SUBURBS WITHIN CATCHMENT

Top Suburbs within Catchment	No. of Homeless Persons	% within Catchment
Heidelberg West	188	4.5%
Hawthorn	135	3.3%
Kew	109	2.6%
Croydon	189	4.6%
Clayton	261	6.3%
Oakleigh-Huntingdale	165	4.0%
Box Hill	128	3.1%
Burwood	152	3.7%
Lalor	101	2.4%
Thomastown	106	2.6%
EMPHN	4147	37.0%

Source: Census of Population and Housing: Estimating homelessness, 2011

3.8 Mental Health & Drug and Alcohol

Table 7 below details the number per 1000 of mental health clients and Drug and alcohol clients in each LGA. Whittlesea shows the highest number of mental health clients and Yarra Ranges has both high numbers of mental health clients and drug and alcohol clients.

TABLE 9 - MENTAL HEALTH & DRUG AND ALCOHOL

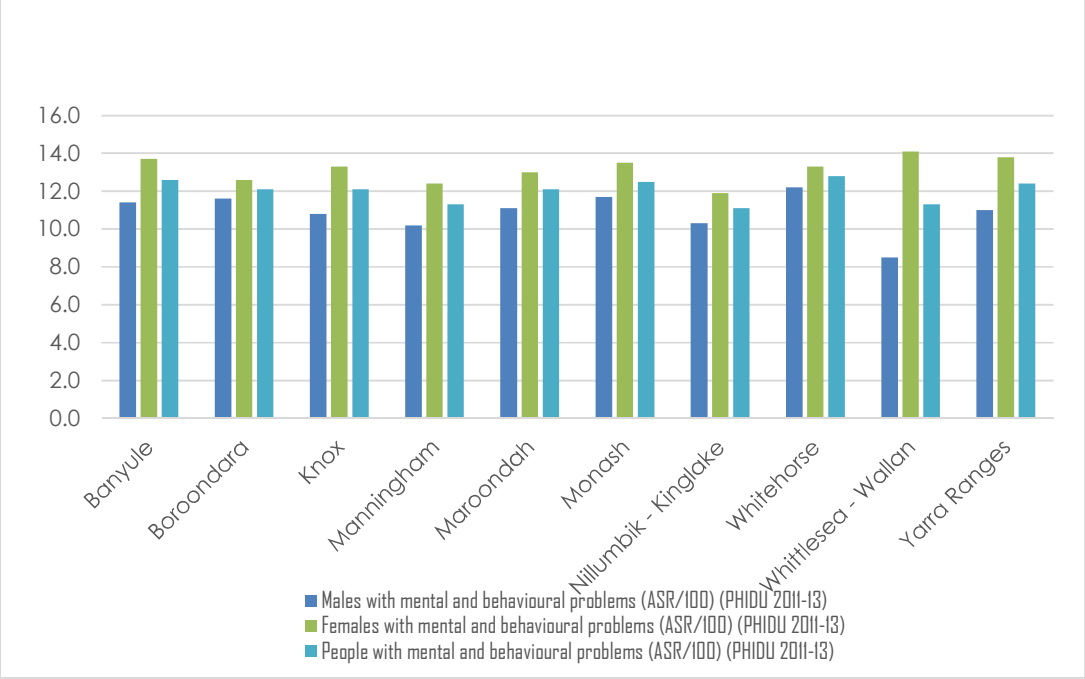
Local Government Areas	Registered Mental Health Clients (Per 1,000) (DH2012)	Drug and alcohol clients (per 1,000)
Banyule	9.0	4.0
Boroondara	6.6	2.8
Knox	8.5	5.4
Manningham	5.2	2.3
Maroondah	9.5	4.8
Monash	6.0	2.1
Nillumbik	5.2	2.3
Whitehorse	7.9	3.5
Whittlesea	9.7	3.7
Yarra Ranges	9.1	5.1
EMPHN	7.7	3.6

Source: Department of Health 2012

3.9 Mental And Behavioural Problems

Figure 2 below indicates the rates per 100 of males, females and persons with mental and behavioural problems. Females seem to have higher rates than males across all LGAs.

FIGURE 2 - RATES OF MENTAL AND BEHAVIOURAL PROBLEMS BY GENDER

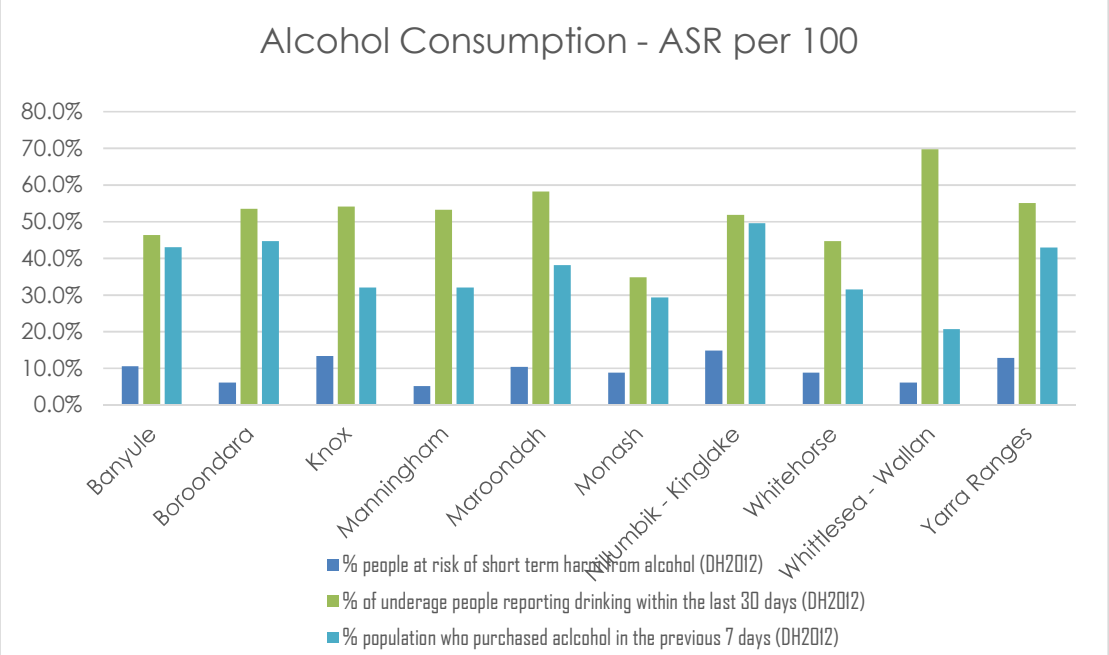


Source: PHIDU 2011-13

3.10 Alcohol Consumption

Figure 3 below shows areas where people are experiencing problems with alcohol. There are high numbers of underage people reporting drinking alcohol in Whittlesea, Maroondah and the Yarra Ranges. People at risk from harm reside mostly in Knox, Nillumbik and the Yarra Ranges.

FIGURE 3 - RATES OF ALCOHOL CONSUMPTION BY LGA ASR PER 100



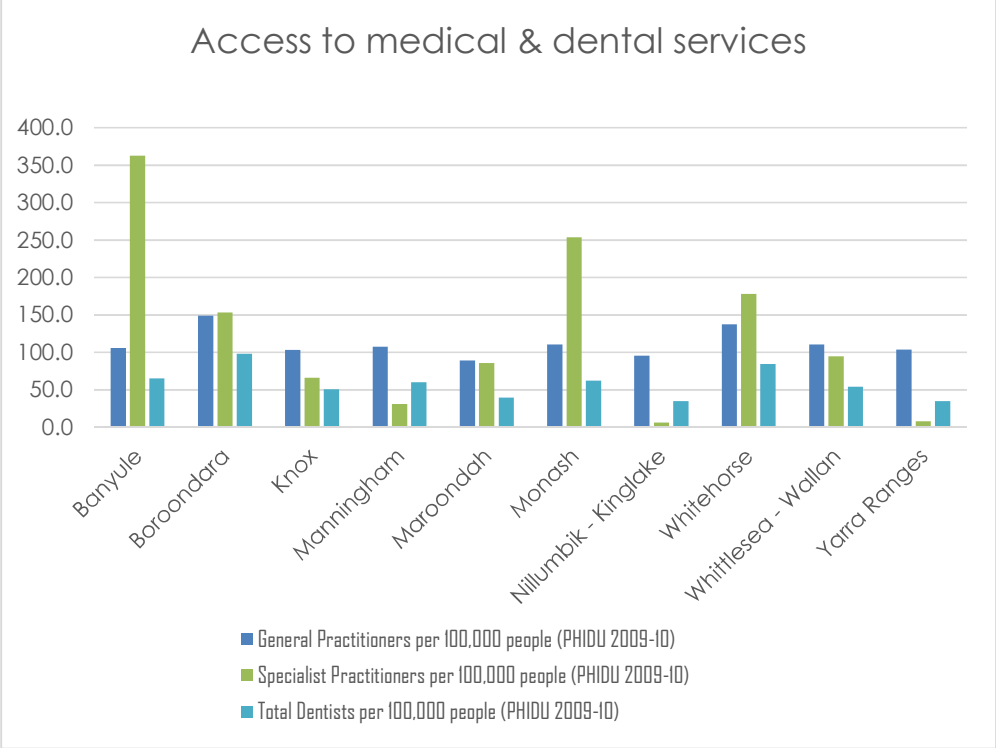
Source: Department of Health 2012

4. WHAT WE KNOW ABOUT ACCESS TO HEALTHCARE

4.1 GENERAL ACCESS TO MEDICAL AND DENTAL SERVICES

In Figure 4 below, the rates of General practitioners, Specialist and Dentists per 100,000 people are compared across the ten LGAs. The rates for GP's appear fairly similar across all the LGAs. Specialists are often associated with particular hospitals so it is not unexpected that Banyule, Monash and Whitehorse would have high rates of specialists.

FIGURE 4 - ACCESS TO MEDICAL & DENTAL SERVICES (LGA)

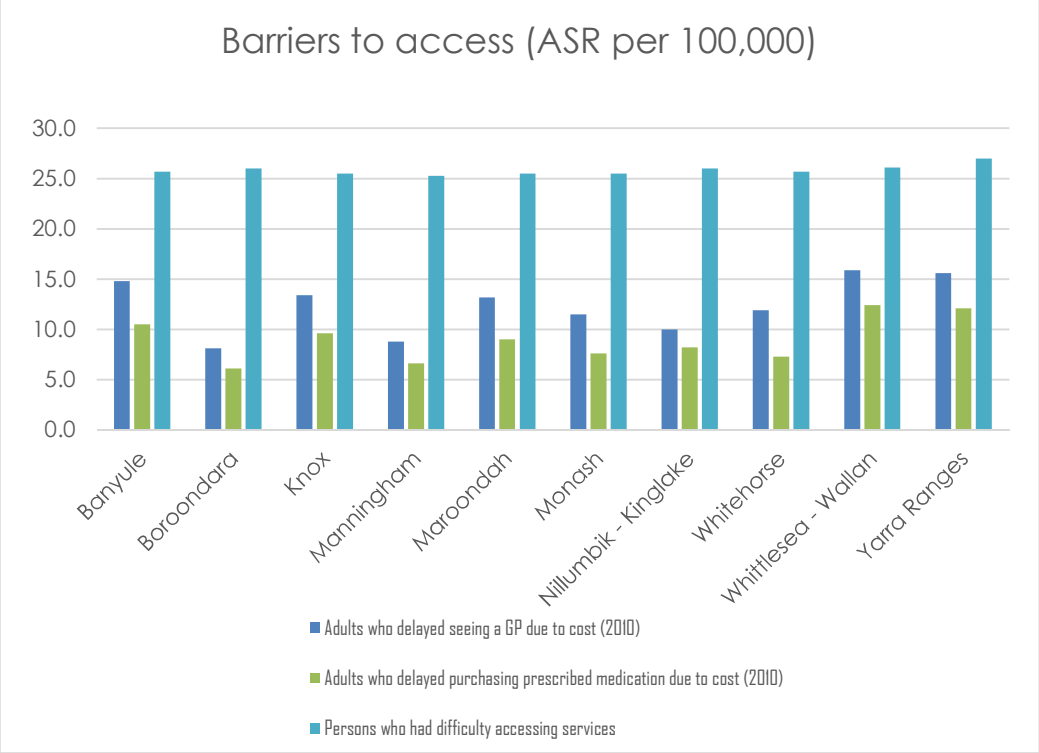


Source: PHIDU 2009-10

4.2 BARRIERS TO ACCESS

Figure 5 below indicated the identified barriers to healthcare access. Across all LGAs it can be seen that accessing services was the most significant barrier followed by adults who delayed seeing a GP due to costs; and purchasing prescribed medication due to cost.

FIGURE 5 - IDENTIFIED BARRIERS TO ACCESS



Source: EMML 2010

4.3 Residential Aged Care Facilities

Table 8 below compares the number of allocated aged care places by planning region in Victoria. The Eastern metro region has the second highest number of residential aged care places in Victoria.

TABLE 10 – ALLOCATED AGED CARE PLACES

Planning Region	Residential care[1]	Home care[2]			Total residential + home care	Total restorative care[3]	Grand Total
		Low care	High care	Total home care			
Barwon-South Western	5,260	1,077	427	1,504	6,764	85	6,849
Eastern Metro	13,079	2,796	1,195	3,991	17,070	155	17,225
Gippsland	3,748	840	349	1,189	4,937	42	4,979
Grampians	2,877	643	257	900	3,777	63	3,840
Hume	3,546	819	334	1,153	4,699	73	4,772
Loddon-Mallee	4,204	968	425	1,393	5,597	101	5,698
Northern Metro	8,826	2,040	753	2,793	11,619	117	11,736
Southern Metro	14,802	3,176	1,308	4,484	19,286	227	19,513
Western Metro	7,050	1,545	620	2,165	9,215	137	9,352
Victoria	63,392	13,904	5,668	19,572	82,964	1,000	83,964

Source: Australian Government, Department of Health, June 2016

- Residential care includes flexible residential care places in the: Multi-Purpose Service (MPS) Programme, Aged Care Innovative Pool Programme and the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme.
- Home care (High care) includes Home care Level 3 and Level 4 places only. Home care (Low care) includes Home care Level 1 and Level 2 places and the flexible Home care places in the: Multi-Purpose Service (MPS) Programme, Aged Care Innovative Pool Programme and the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme.
- Restorative care includes places in the Transition Care Programme and the Short-Term Restorative Care Programme. As at 30 June 2016, restorative care includes places in the Transition Care Programme only. New places in the Short-Term Restorative Care Programme will progressively become available from 2016-17.

RESIDENTIAL IN REACH

Residential In Reach services are available as shown in the following table which shows extensive RIR services across the catchment.

TABLE 11 - RIR

Organisation	LGAs covered	Service	Hours
Austin Health	Banyule, Darebin, Nillumbik and Manningham	Phone consultations / advice / triage	Mon-Sun: 9am-5pm
		On-site assessments by a nurse consultant	Mon-Sun: 9am-5pm
		On-site assessments by a geriatric registrar	Mon-Fri: 9am-5pm
Eastern Health	Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse and Yarra Ranges	Phone consultations / advice / triage	Mon to Fri 8.00am - 9.30pm, Sat & Sun 8.30am—4.30pm
		On-site assessments by a nurse consultant	Mon to Fri 8am - 4.30pm, Sat & Sun 8am—4.30pm
		On-site assessments by a geriatric registrar	Mon to Fri 9am—4.30pm
Northern Health	Nillumbik, Banyule, Hume, Moreland, Darebin and Whittlesea	Phone consultations / advice / triage	Fri and Mon: 8am-8pm Tues, Wed and Thurs: 8am-4.30pm Sat and Sun: 10am-4.30pm
		On-site assessments by a clinical nurse consultant	Fri and Mon: 9am-8pm Tues, Wed and Thurs: 9am-4pm Sat and Sun: 10am-4.30pm
		On-site assessments by a Ages Care registrar	Mon-Fri: 9am-4pm Thurs: 9am-12pm
Monash Health	(in EMPHN catchment) Monash, Knox	Phone consultations / advice / triage	24 hours a day, 7 days a week
		On-site assessment by nurse consultant	8.30am – 9.00am 7 days a week
		On-site assessments by a geriatric registrar	8.30am–8.00pm Mon to Fri, 2.00pm–8.00pm Sat, 9.00am–3.00pm Sun
St. Vincent's Hospital	(in EMPHN catchment) Boroondara	Phone consultations / advice / triage	8.00am–8.00pm Mon to Fri, 8.00am–4.00 pm Sat & Sun
		On-site assessment by nurse consultant	8.00am–8.00pm Mon to Fri, 8.00am–4.00pm Sat & Sun
		On-site assessments by a geriatric registrar	9.00am–5.00pm Mon to Fri

Source: EMPHN 2017

4.4 Emergency Departments After Hours

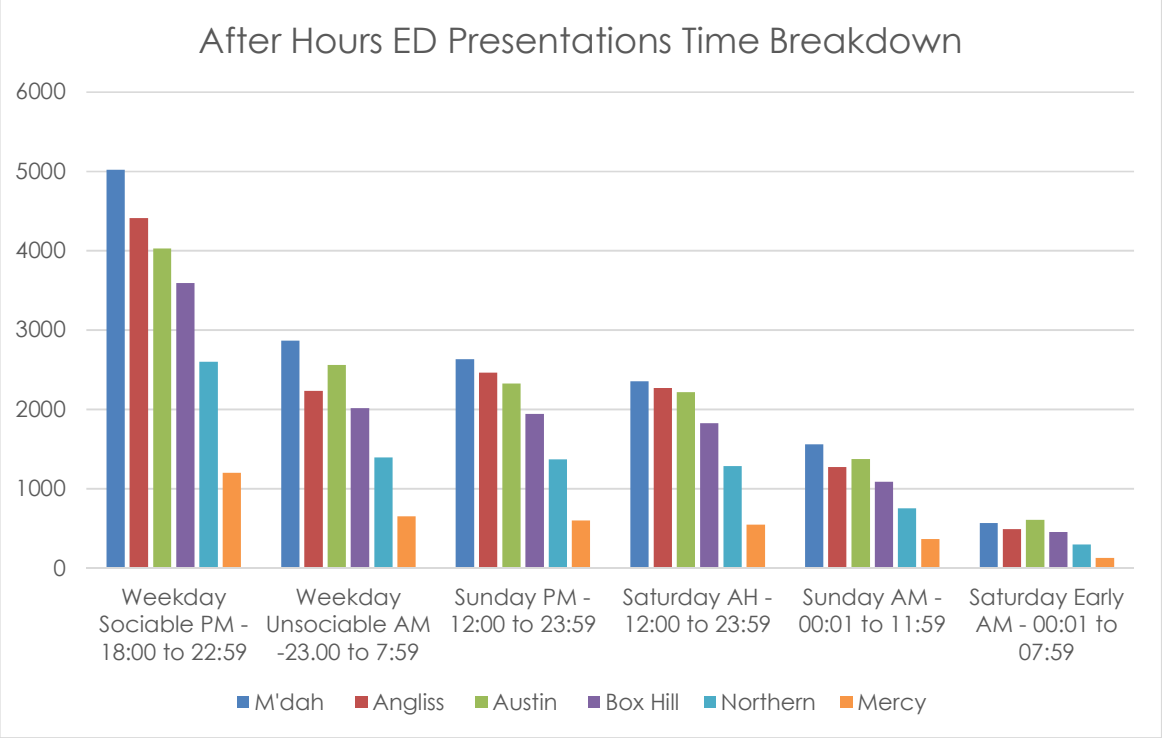
There are 8 hospitals with public hospital emergency departments in the catchment, including the Mercy Hospital for Women. Most of these hospitals are located in the inner suburbs of the catchment, except for the Healesville and District Hospital. Residents of the outer suburbs around Upper Plenty, Whittlesea, King Lake West and King Lake are further away from the nearest hospital with public emergency.

Emergency Departments categorise all patients as follows:

- **Category 1**– immediately life-threatening patients – these patients should be seen by a treating doctor or nurse within 2 minutes of arriving.
- **Category 2**– imminently life-threatening patients – these patients should be seen by a treating doctor or nurse within 10 minutes of arriving.
- **Category 3**– potentially life-threatening patients – these patients should be seen by a treating doctor or nurse within 30 minutes of arriving.
- **Category 4**– potentially serious patients – these patients should be seen by a treating doctor or nurse within 60 minutes of arriving.
- **Category 5**– less urgent patients – these patients should be seen by a treating doctor or nurse within 120 minutes of arriving.

Emergency department presentations for category four and five are generally 'primary care type' and the number of presentations during the designated After Care hours are shown in the following chart. The majority of 'primary care' type hospital presentations during the week are in the sociable hours from 18:00 to 22:59 followed by weekday presentation in the unsociable hours from 23.00 to 7:59. Presentations on Sundays from 12:00 to 23:59 and Saturdays from 12:00 to 23:59 are the next highest. This is followed by Sundays from 00.01 to 11.59 and Saturday in the early morning between 00.01 to 07.59.

FIGURE 6: CATEGORY 4 AND 5 EMERGENCY DEPARTMENT PRESENTATIONS 2014-15 BY HOSPITAL

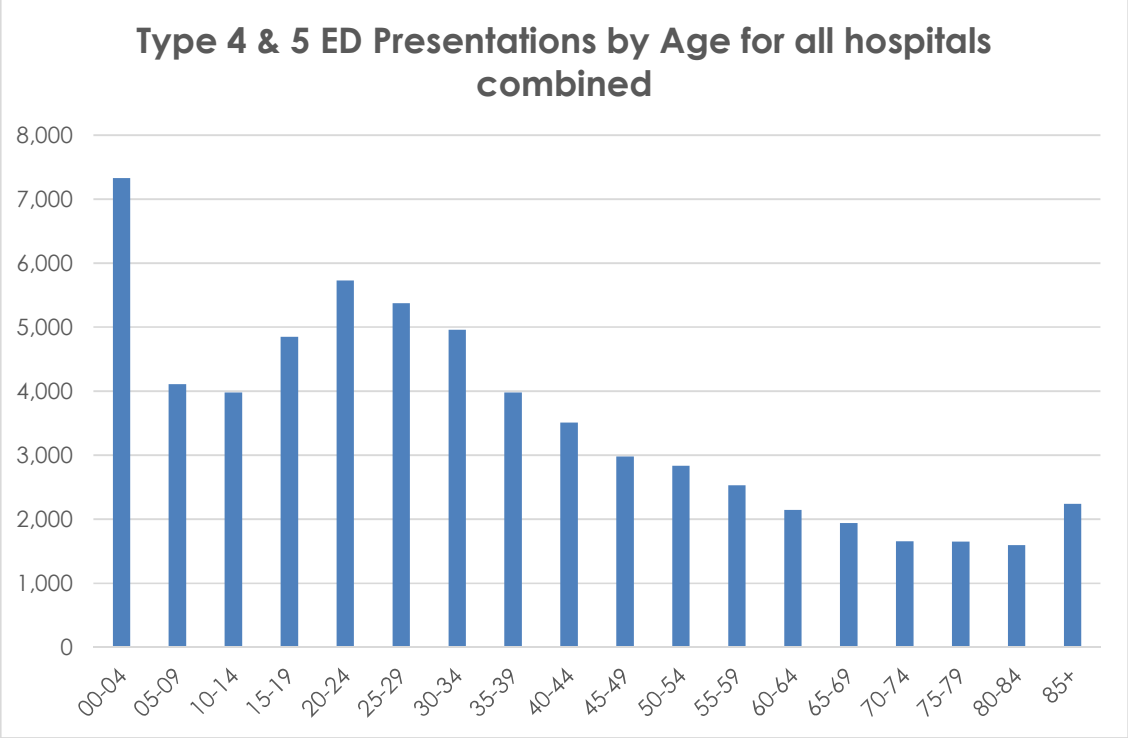


Source: Victorian Emergency Minimum Dataset 2014-15

Please note the data provided by EMPHN has been re-categorised to bring together the data for unsociable weekday hours. The data for the hours of 23 – 23.59 and 0.00 to 7.59 have been combined.

Figures 7 and 8 below show patients presenting to ED for Category 4 and 5 type care categorised by age. Patients aged 0-4 years are the majority of patients presenting to ED with a spike around the child bearing years and then increasing for patients aged 85 plus.

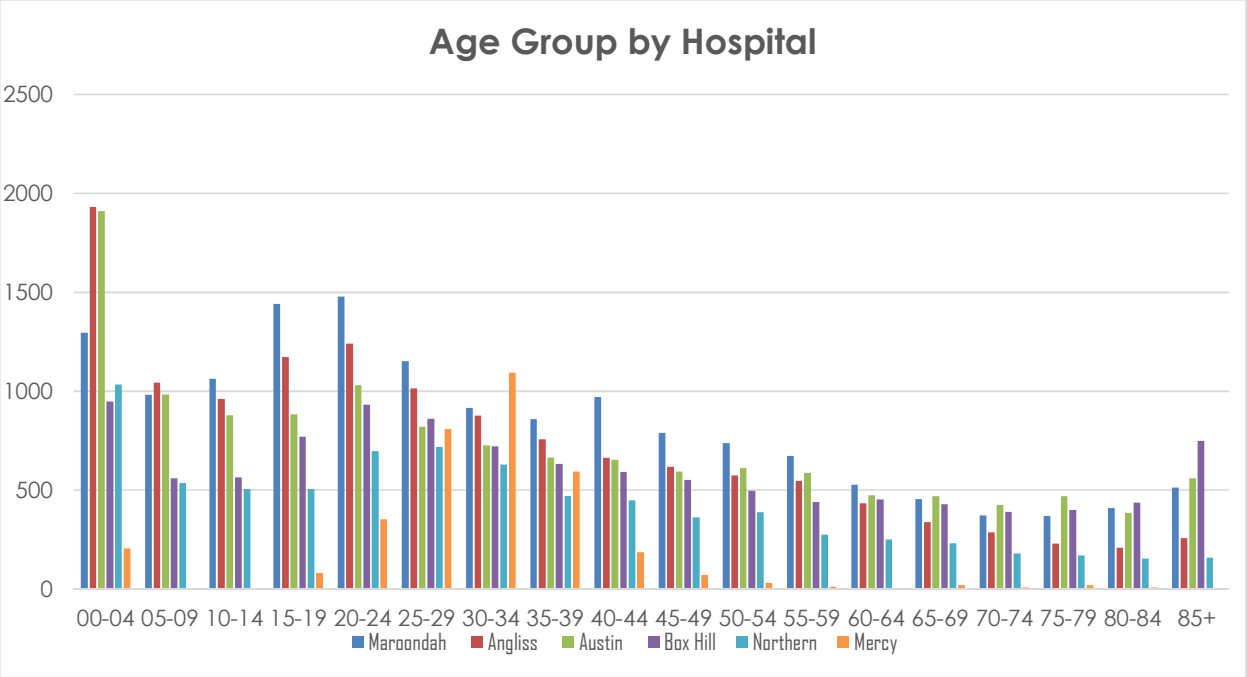
FIGURE 7 - CATEGORY 4 AND 5 EMERGENCY DEPARTMENT PRESENTATIONS 2014-15 BY AGE OF PATIENT



Source: Victorian Emergency Minimum Dataset 2014-15

Different hospitals have different presentations. As shown in the chart below, young children aged between 0 and 4 years mainly present to Angliss and Austin Hospitals. The Mercy hospital presentations are predominantly female and aged between 25 and 40 and are presumably pregnancy related.

FIGURE 8 - CATEGORY 4 AND 5 EMERGENCY DEPARTMENT PRESENTATIONS 2014-15 BY AGE OF PATIENT AND HOSPITAL



Source: Victorian Emergency Minimum Dataset 2014-15

Table 9 below shows that apart from the Mercy hospital which is a maternity hospital, the percentage of category 4 and 5 presentations at hospitals by males to females does not vary greatly.

TABLE 12 - CATEGORY 4 AND 5 EMERGENCY DEPARTMENT PRESENTATIONS 2014-15 BY GENDER

Male/Female Breakdown						
	Maroondah	Angliss	Austin	Box Hill	Northern	Mercy
Male	52.1%	49.1%	50.8%	49.6%	50.9%	4.3%
Female	47.9%	50.9%	49.2%	50.4%	49.1%	95.7%

Source: Victorian Emergency Minimum Dataset 2014-15

Category 4 and 5 presentations at emergency departments are shown by LGA in the following table. Whittlesea and the Yarra Ranges had higher number per 100,000 of primary care type ED presentations than the other suburbs. This is supported by the higher rate of overall ED presentations of people from these LGA's. The lack of GP services and after hour services may be a factor. All the LGAs had similar proportions of presentations for Primary Care type issues which ranged from 44.1% in Whittlesea to 56.1%

in Maroondah. Slightly more than half of these primary care type presentations were during after hours across all LGAs.

TABLE 13 - EMERGENCY DEPARTMENT PRESENTATIONS FOR CATEGORY 4 & 5 BY LGA IN 2012-13

Local Government Areas	ED Presentations per 100,000	Primary care type ED presentations (Code: 4 & 5)	% of total ED presentation	% Cat. 4&5 During Business hours	% Cat. 4&5 During After hours
Banyule	25753	16490	51.0%	43.3%	56.7%
Boroondara	13185	11776	51.7%	44.0%	56.0%
Knox	25584	21295	53.5%	44.0%	56.0%
Manningham	20098	11776	54.0%	42.8%	52.4%
Maroondah	26644	14936	56.1%	45.5%	54.5%
Monash	18470	17613	51.5%	42.9%	57.1%
Nillumbik	17388	6147	46.7%	45.3%	54.7%
Whitehorse	19220	14060	44.7%	44.6%	55.4%
Whittlesea	30788	28817	44.1%	48.2%	51.8%
Yarra Ranges	28527	22676	53.0%	47.7%	52.3%

Source: IEMML 2012-13

4.5 AFTER HOURS PRIMARY HEALTHCARE SERVICES AVAILABILITY

4.5.1 AFTER HOURS SERVICES PROVIDED

After hour services provided in the EMPHN catchment by MDSs totalled over 70,000 in 2013-14. Nearly 40% of these were to for residents in Residential Aged Care Facilities – *see table below.*

TABLE 14 - AFTER HOURS SERVICES PROVIDED BY MEDICAL DEPUTISING SERVICES - ALMS & MMD IN 2013-14

Local Government Area	Total number of Call outs	Call outs per 10,000 people	Number of RACF call outs	% of total
Banyule	2,870	2.3	827	28.8%
Boroondara	13,206	7.6	5,454	41.3%
Knox	2,482	1.6	361	14.5%
Manningham	10,939	9.2	4,384	40.1%
Maroondah	4,220	3.8	1,962	46.5%
Monash	14,214	7.8	4,793	33.7%
Nillumbik	169	0.3	1	0.6%
Whitehorse	14,670	8.9	6,757	46.1%
Whittlesea	4,274	2.3	1,275	29.8%
Yarra Ranges	3,505	2.3	1,632	46.6%
Total SMPHN	70,549		27,,446	38.9%

Source: EMPHN 2017

4.5.2 Medical Deputising Service coverage

Coverage by medical deputising services is fairly comprehensive in the inner eastern suburbs. Other areas have little or no coverage such as Murrindindi, Mitchell, Whittlesea, Yarra Ranges and Upper Yarra Ranges (which has no coverage); and there is moderate coverage in the suburbs of Nillumbik – see table below.

TABLE 15 – MDS SERVICE GEOGRAPHIC COVERAGE

LGA	No. of Suburbs	National Home Doctor Service - NHDS	My Home GP	Doctor Doctor
Banyule	19	100%	100%	100%
Boroondara	14	100%	100%	100%
Knox	11	100%	100%	100%
Manningham	9	100%	100%	100%
Maroondah	13	100%	100%	100%
Mitchell	3	0%	0%	33%
Monash	12	100%	100%	100%
Murrindindi	4	0%	0%	0%
Nillumbik	21	67%	62%	57%
Whitehorse	15	100%	100%	100%
Whittlesea	33	33%	18%	30%
Yarra Ranges	48	27%	2%	54%
Upper Yarra Ranges	7	0	0	0*
* Pilot Project in 2 suburbs				

Source: EMPHN 2017

HOT SPOTS: SUBURBS WITH LOW OR NON-EXISTENT COVERAGE BY MDS

Suburbs with low or non-existent coverage by MDS are listed below.

Hot Spots, i.e. suburbs with low or non-existent coverage by MDS and limited clinics are identified in the table below.

TABLE 16: MDS COVERAGE BY LGA AND SUBURB

LGA	Suburbs with no services provided by NHDS, My Home GP or Doctor Doctor	Suburbs with limited services provided
Murrindindi	Castella, Kinglake, Kinglake-West and Toolangi	
Mitchell	Beveridge, Wallan and Wollert	
Nillumbik	Arthurs Creek, Bend of Islands, Kangaroo Ground, Kinglake, Nutfield, Strathewen, and Watson Creek	Cottles Bridge, Kinglake and Warrandyte North
Whittlesea	Broadford, Chintin, Clonbinane, Darraweit-Guim, Eden Park, Heathcote Junction, Humevale, Kinglake Central, Pheasant Creek Reedy Creek, Smiths Gully, St Andrews, Strath Creek, Sugarloaf Creek, Sunday Creek, Tyaak, Upper Plenty, Waterford Park	Beveridge, Hazeldene, Panton Hill, Wallan, Wandong, Whittlesea, Wollert, Woodstock and Yan Yean.
Yarra Ranges and the Upper Yarra Ranges	Badger, Christmas Hills, Chum Creek, Dixons Creek, don Valley, Gruyere, Healesville, Hoddles Creek, Launching Place, Millgrove, Powelltown, Seville, Seville East, Tarrawarra, Wandin-East, Wandin-North, Warburton, Warburton East, Wesburn, Woori Yallock, Yarra Glen, Yarra Junction, Yellingbo and Yering	Belgrave, Belgrave Heights, Chirnside Park, Coldstream, Emerald, Ferny Creek, Kallista, Kalorama, Kilsyth, Lilydale, Macclesfield, Menzies Creek, Monbulk, Montrose, Mooroolbark, Mount Dandenong, Mount Evelyn, Olinda, Sassafras, Selby, Sherbrook, Tecoma, The Patch, Tremont, and Upwey

Source: EMPHN 2017

2017 research has found that rapid increases (increasing by 170% over the study period 2010/11 – 2015/16) in after-hours claims for MBS item number 597 (urgent, sociable after-hours consultations) have coincided with the introduction of AHMDSs in three jurisdictions (ACT, Tasmania and NT). The impact on patient outcomes and equitable resource distribution requires attention.

The use of AHMDSs has been indirectly supported through the Department of Health's Practice Incentives Program: After Hours Incentives. The data suggest that AHMDSs may not be operating these services as intended (i.e. supporting general practice) (de Graff, et al., 2017).

According to the Health Insurance Act 1973, an AHMDS is required to enter into a formal deputising arrangement with a general practice. It is therefore possible for an AHMDS to have only a small number of

formal arrangements with general practice, with the great majority of patients accessing the service via self-referral. No data are publicly available regarding patient pathways to AHMDSs and the proportion of patients accessing services under formal agreements (de Graff, et al., 2017).

The researchers state that it can be argued that AHMDSs are marketing themselves directly to the community using multi-platform advertising approaches. Further, Given that after-hours general practice clinics are operating in urban areas – areas that should have the critical mass to sustain them – it is questionable why such services are not being preferentially supported in the after-hours period. Funding models that target support of after-hour clinics can assist with the financial sustainability of these services, while providing comprehensive patient care (de Graff, et al., 2017).

The researchers propose evaluations to assess how patient outcomes are affected by increased use of these services particularly in relation to continuity of care, including timely provision of clinical summaries to the patient's regular GP by the AHMDS. A second key issue relates to the equitable distribution of resources. As AHMDSs have only been established in metropolitan and large regional settings (de Graff, et al., 2017).

An article 'After-hours home doctor services deemed poor value for money by taskforce' by Harriet Alexander in The Age on the 8th June, 2017 presenting this research stated that:

- Many urgent after-hours services claimed as urgent are not truly urgent, as intended when the items were created, and the distinction between 'urgent' and 'non-urgent' appears not to be well understood by many medical practitioners.
- Nearly 80 per cent of doctors employed by the providers are on a training pathway and not registered GPs, so they would not be eligible for the higher rebate and it would not make financial sense for them to do after-hours work.
- Research published in the Australian Family Physician last month indicated that the growth in after-hours services had not reduced the number of emergency department admissions, which continued to increase along the same trajectory they were on before the services were established.

The Royal Australian College of General Practitioners president Bastian Seidel said it was appropriate that only GPs who normally worked during the day were eligible for the higher rebate. "This would deliver better outcomes for patients because the healthcare provided would be based on the GP's deeper knowledge of the patient's circumstances, better access to their health records and better follow-up to ensure continuity of care," Dr Seidel said.

4.5.3 GP Clinics Open After Hours

Table 16 below shows that in 2017 there are 189 GP clinics in the catchment that open after hours. The majority of these GP Clinics (97) only open from 1 to 9 hours per week. There are 27 clinics that open after hours more than 31 hours per week. The Unsociable hours on weekdays from 23.00 pm to 7.59 am are the ones with the least coverage.

TABLE 17 – GP CLINICS OPERATING AFTER HOURS

After Hours GP Clinics Opening Hours		Sociable Hours Week Days	Unsociable Hours Week Days	Saturday Unsociable Hours	Sunday Unsociable Hours	Public Holidays	Total No. of Clinics Open	Number bulkbilling only
From 1 to 9 hours per week	No. of Clinics Open	57	1	61	20	8	**97**	18
	Total Hours open	215.5	5	118.5	68.5	19.5		
	Average hours open	3.8	5.0	1.9	3.4	2.4		
From 10 to 15 hours per week	No. of Clinics Open	34	1	24	23	4	**36**	9
	Total Hours open	266	1	76.5	94.5	15		
	Average hours open	7.8	1.0	3.2	4.1	3.8		
From 16 to 20 hours per week	No. of Clinics Open	8	0	7	5	2	**8**	2
	Total Hours open	97.5	0	23.3	20.3	8		
	Average hours open	12.2	0.0	3.3	4.1	4.0		
From 21 to 30 hours per week	No. of Clinics Open	21	2	21	20	9	**21**	5
	Total Hours open	272	4	92.5	138	54.5		
	Average hours open	13.0	2.0	4.4	6.9	6.1		
From 31 hours plus	No. of Clinics Open	27.0	13.0	27.0	27.0	17.0	**27**	13
	Total Hours open	557.5	143.5	245.3	345.5	189		
	Average hours open	20.6	11.0	9.1	12.8	11.1		
Total Clinics Open After Hours		147.0	17.0	140.0	95.0	40.0	**189**	47

Source: EMPHN 2017

The hours that clinics are open in each LGA and suburbs are illustrated below for each LGA.

Banyule – includes the 21 suburbs of:

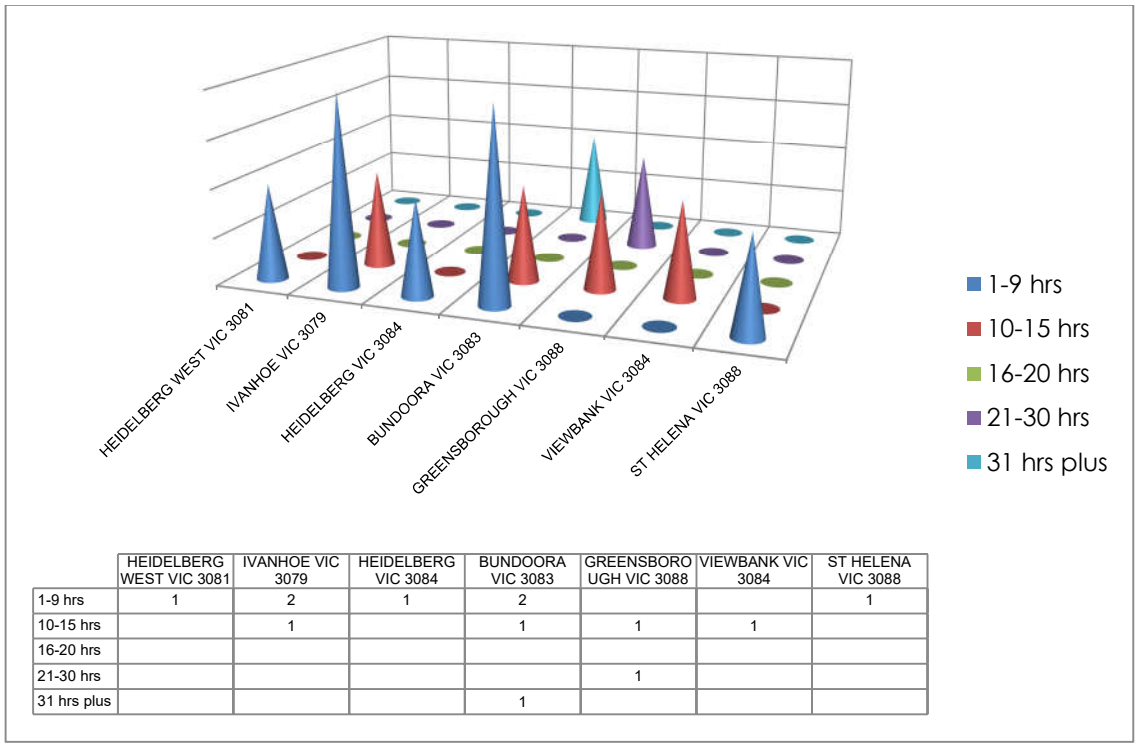
1. Bellfield 3081
2. Briar Hill 3088
3. Bundoora 3083 (shared with City of Darebin and City of Whittlesea)
4. Eaglemont 3084
5. Eltham 3095
6. Eltham North 3095 (shared with Shire of Nillumbik)
7. Greensborough 3088 (shared with Shire of Nillumbik)
8. Heidelberg 3084
9. Heidelberg Heights 3081
10. Heidelberg West 3081
11. Ivanhoe 3079
12. Ivanhoe East 3079

13. Lower Plenty 3093
14. Macleod 3085 (shared with City of Darebin)
15. Montmorency 3094
16. Rosanna 3084
17. St Helena 3088
18. Viewbank 3084
19. Watsonia 3087
20. Watsonia North 3087
21. Yallambie 3085

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Bellfield 3081
- Briar Hill 3088
- Eaglemont 3084
- Eltham 3095
- Eltham North 3095 (shared with Shire of Nillumbik)
- Heidelberg 3084
- Heidelberg Heights 3081
- Ivanhoe East 3079
- Lower Plenty 3093
- Macleod 3085 (shared with City of Darebin)
- Montmorency 3094
- Rosanna 3084
- Watsonia 3087
- Watsonia North 3087
- Yallambie 3085

FIGURE 7: BANYULE CLINIC OPENING HOURS AND SUBURBS



	HEIDELBERG WEST VIC 3081	IVANHOE VIC 3079	HEIDELBERG VIC 3084	BUNDOORA VIC 3083	GREENSBOROUGH VIC 3088	VIEWBANK VIC 3084	ST HELENA VIC 3088
1-9 hrs	1	2	1	2			1
10-15 hrs		1		1	1	1	
16-20 hrs							
21-30 hrs					1		
31 hrs plus				1			

Source: EMPHN 2017

Boroondara - includes the 14 suburbs of:

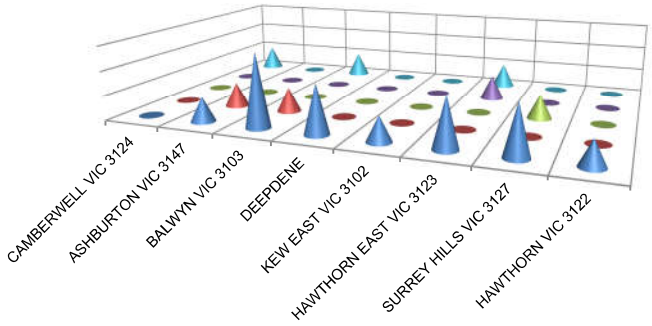
1. Ashburton 3147
2. Balwyn 3103
3. Balwyn North 3104
4. Camberwell 3124
5. Canterbury 3126
6. Deepdene 3103
7. Glen Iris 3146 (Shared with City of Stonnington)
8. Hawthorn 3122
9. Hawthorn East 3123
10. Kew 3101
11. Kew East 3102
12. Mont Albert 3127 (Shared with City of Whitehorse)
13. Mont Albert North 3127
14. Surrey Hills 3127 (Shared with City of Whitehorse)

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Canterbury 3126
- Glen Iris 3146 (Shared with City of Stonnington)

- Kew 3101
- Mont Albert 3127 (Shared with City of Whitehorse)
- Mont Albert North 3127

FIGURE 8: BOROONDARA CLINIC OPENING HOURS AND SUBURBS



	CAMBERWELL VIC 3124	ASHBURTON VIC 3147	BALWYN VIC 3103	DEEPDENE	KEW EAST VIC 3102	HAWTHORN EAST VIC 3123	SURREY HILLS VIC 3127	HAWTHORN VIC 3122
1-9 hrs	0	1	3	2	1	2	2	1
10-15 hrs	0	1	1	0	0	0	0	0
16-20 hrs	0	0	0	0	0	0	1	0
21-30 hrs	0	0	0	0	0	1	0	0
31 hrs plus	1	0	1	0	0	1	0	0

Source: EMPHN 2017

Knox - includes the 11 suburbs of:

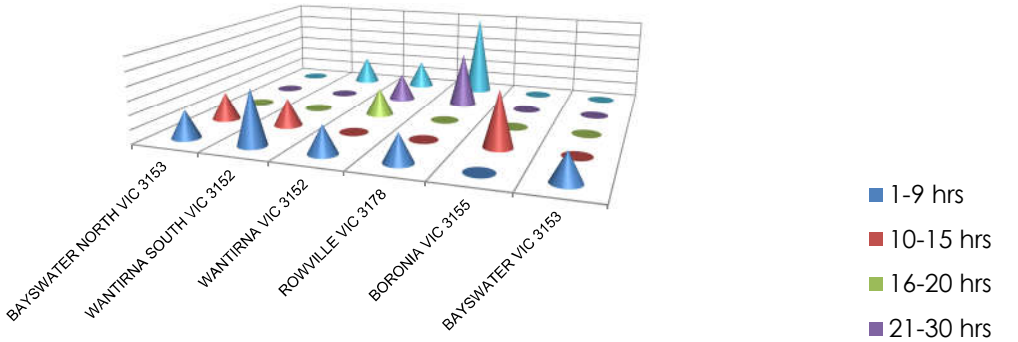
1. Bayswater 3153
2. Boronia 3155
3. Ferntree Gully 3156
4. Knoxfield 3180
5. Lysterfield 3156 (shared Shire of Yarra Ranges)
6. Rowville 3178
7. Scoresby 3179
8. The Basin 3154
9. Upper Ferntree Gully 3156 (shared Shire of Yarra Ranges)
10. Wantirna 3152
11. Wantirna South 3152

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Ferntree Gully 3156
- Knoxfield 3180
- Lysterfield 3156 (shared Shire of Yarra Ranges)
- Scoresby 3179

- The Basin 3154
- Upper Ferntree Gully 3156 (shared Shire of Yarra Ranges)

FIGURE 9: KNOX CLINIC OPENING HOURS AND SUBURBS



	BAYSWATER NORTH VIC 3153	WANTIRNA SOUTH VIC 3152	WANTIRNA VIC 3152	ROWVILLE VIC 3178	BORONIA VIC 3155	BAYSWATER VIC 3153
1-9 hrs	1	2	1	1	0	1
10-15 hrs	1	1	0	0	2	0
16-20 hrs	0	0	1	0	0	0
21-30 hrs	0	0	1	2	0	0
31 hrs plus	0	1	1	3	0	0

Source: EMPHN 2017

Manningham - includes the 12 suburbs of:

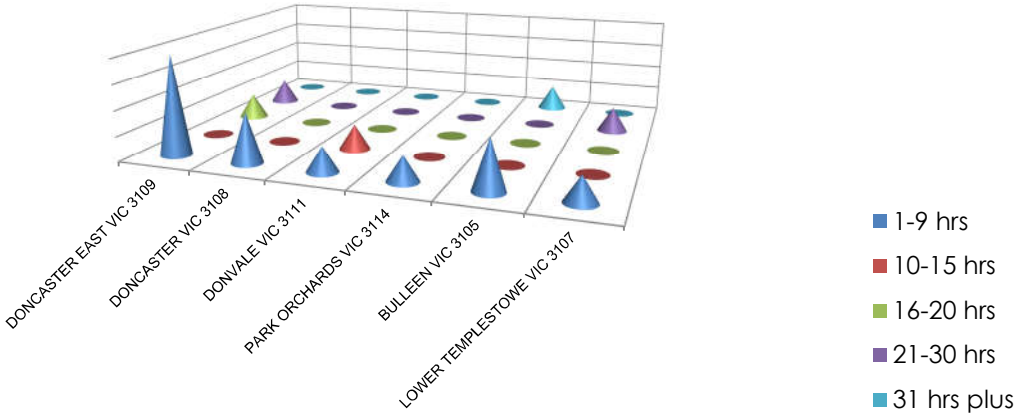
1. Bulleen 3105
2. Doncaster 3108
3. Doncaster East 3109
4. Donvale 3111
5. Park Orchards 3114
6. Templestowe 3106
7. Templestowe Lower 3107
8. Warrandyte 3113
9. Warrandyte South 3134
10. Wonga Park 3115
11. Nunawading 3131 (Shared with City of Whitehorse)
12. Ringwood North 3134 (Shared with City of Maroondah)

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Templestowe 3106
- Warrandyte 3113

- Warrandyte South 3134
- Wonga Park 3115
- Nunawading 3131 (Shared with City of Whitehorse)
- Ringwood North 3134 (Shared with City of Maroondah)

FIGURE 10: MANNINGHAM CLINIC OPENING HOURS AND SUBURBS



	DONCASTER EAST VIC 3109	DONCASTER VIC 3108	DONVALE VIC 3111	PARK ORCHARDS VIC 3114	BULLEEN VIC 3105	LOWER TEMPLESTOWE VIC 3107
1-9 hrs	4	2	1	1	2	1
10-15 hrs	0	0	1	0	0	0
16-20 hrs	1	0	0	0	0	0
21-30 hrs	1	0	0	0	0	1
31 hrs plus	0	0	0	0	1	0

Source: EMPHN 2017

Maroondah - includes the 11 suburbs of:

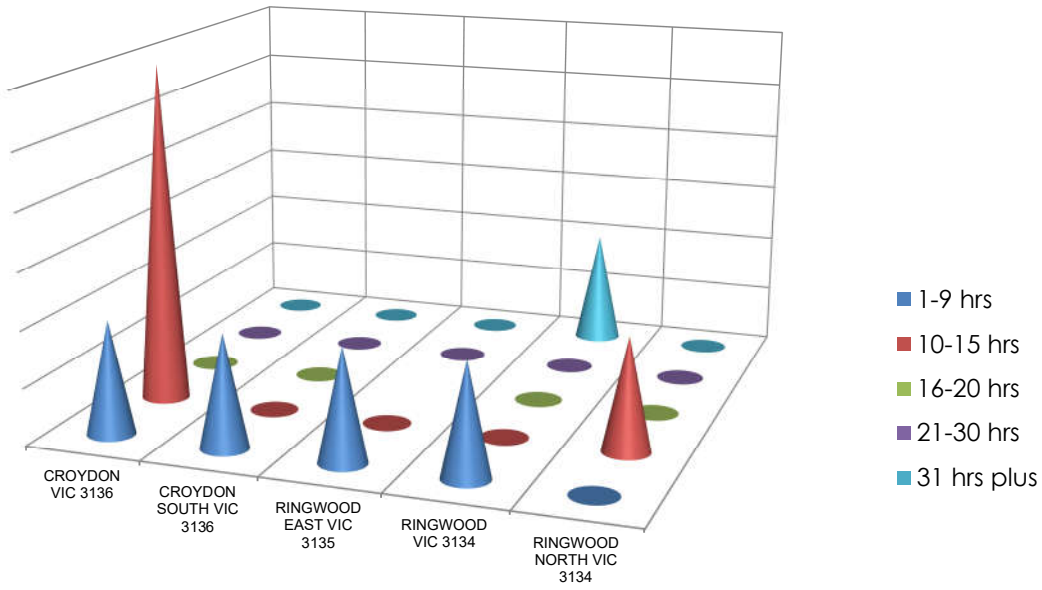
1. Bayswater North 3153
2. Croydon 3136
3. Croydon Hills 3136
4. Croydon North 3136
5. Croydon South 3136
6. Heathmont 3135
7. Kilsyth South 3137
8. Ringwood 3134
9. Ringwood East 3135
10. Ringwood North 3134 (Shared with City of Manningham)
11. Warranwood 3134

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Bayswater North 3153
- Croydon Hills 3136
- Croydon South 3136

- Heathmont 3135
- Kilsyth South 3137
- Ringwood East 3135
- Warranwood 3134

FIGURE 11: MAROONDAH CLINIC OPENING HOURS AND SUBURBS



	CROYDON VIC 3136	CROYDON SOUTH VIC 3136	RINGWOOD EAST VIC 3135	RINGWOOD VIC 3134	RINGWOOD NORTH VIC 3134
1-9 hrs	1	1	1	1	0
10-15 hrs	3	0	0	0	1
16-20 hrs	0	0		0	0
21-30 hrs	0	0	0	0	0
31 hrs plus	0	0	0	1	0

Source: EMPHN 2017

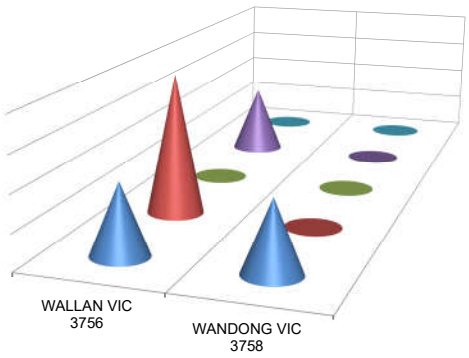
Mitchell Shire - includes the 12 townships of:

1. Beveridge 3753
2. Broadford 3658
3. Heathcote Junction 3758
4. Kilmore 3764
5. Puckapunyal 3662
6. Pyalong 3521
7. Reedy Creek 3658
8. Seymour 3660
9. Tallarook 3659
10. Tooborac 3522
11. Wallan 3756
12. Wandong 3758

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Beveridge 3753
- Broadford 3658
- Heathcote Junction 3758
- Kilmore 3764
- Puckapunyal 3662
- Pyalong 3521
- Reedy Creek 3658
- Seymour 3660
- Tallarook 3659
- Tooborac 3522

FIGURE 12: MITCHELL CLINIC OPENING HOURS AND SUBURBS



	WALLAN VIC 3756	WANDONG VIC 3758
1-9 hrs	1	1
10-15 hrs	2	0
16-20 hrs	0	0
21-30 hrs	1	0
31 hrs plus	0	0

Source: EMPHN 2017

Monash - includes the 15 suburbs of:

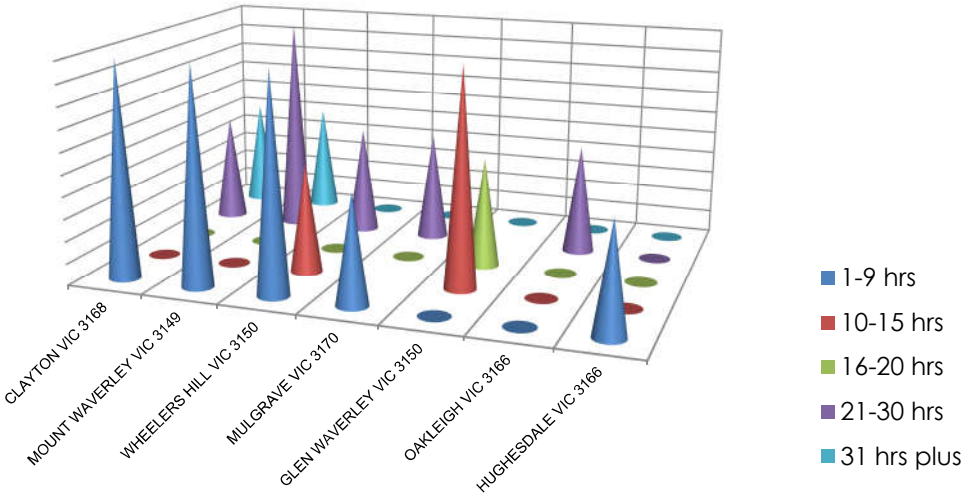
1. Ashwood 3147
2. Burwood 3125 (Shared with City of Whitehorse)
3. Chadstone 3148
4. Clayton 3168
5. Glen Waverley 3150
6. Hughesdale 3166
7. Huntingdale 3166
8. Monash University 3800

9. Mount Waverley 3149
10. Mulgrave 3170
11. Notting Hill 3168
12. Oakleigh 3166
13. Oakleigh East 3166
14. Oakleigh South 3167
15. Wheelers Hill 3150

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Ashwood 3147
- Burwood 3125 (Shared with City of Whitehorse)
- Chadstone 3148
- Huntingdale 3166
- Monash University 3800
- Notting Hill 3168
- Oakleigh East 3166
- Oakleigh South 3167

FIGURE 13: MONASH CLINIC OPENING HOURS AND SUBURBS



	CLAYTON VIC 3168	MOUNT WAVERLEY VIC 3149	WHEELERS HILL VIC 3150	MULGRAVE VIC 3170	GLEN WAVERLEY VIC 3150	OAKLEIGH VIC 3166	HUGHESDALE VIC 3166
1-9 hrs	2	2	2	1	0	0	1
10-15 hrs	0	0	1		2	0	0
16-20 hrs	0	0	0	0	1	0	0
21-30 hrs	1	2	1	1		1	0
31 hrs plus	1	1	0	0	0	0	0

Source: EMPHN 2017

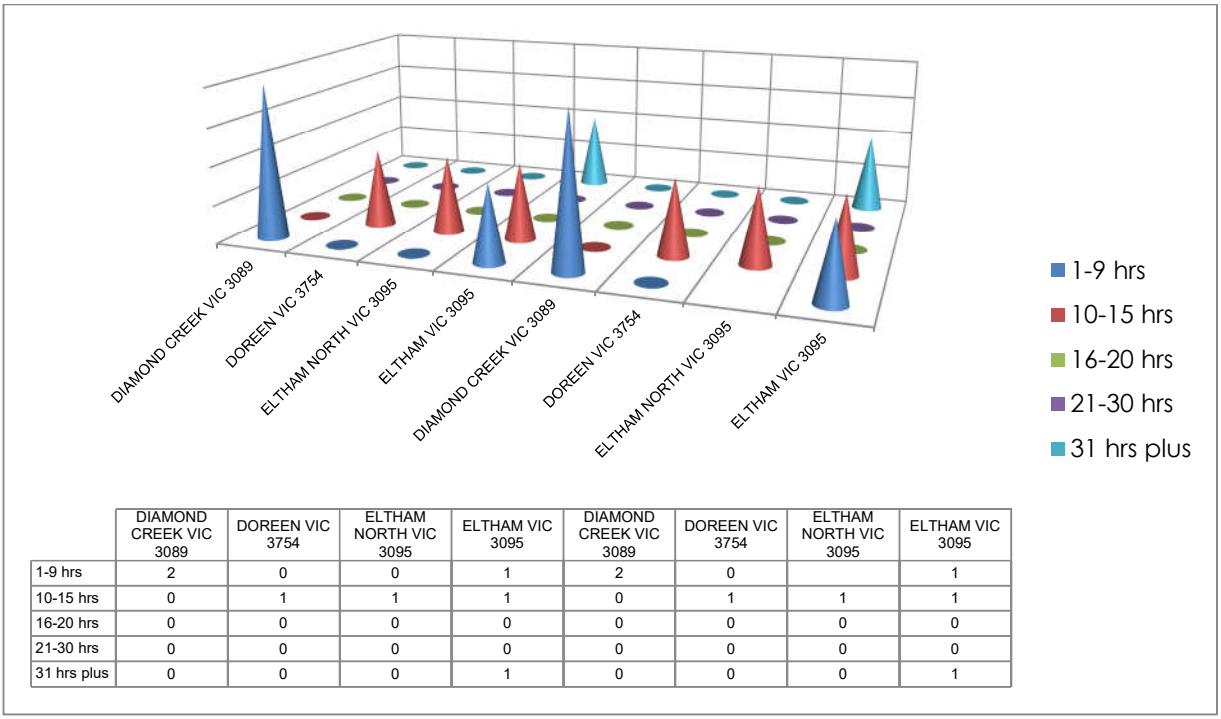
Nillumbik - includes the 8 suburbs of:

1. Diamond Creek 3089
2. Eltham 3095
3. Eltham North 3095 (Shared with City of Banyule)
4. Greensborough 3088 (a small area: Shared with City of Banyule)
5. Hurstbridge 3099
6. North Warrandyte 3113
7. Research 3095
8. Wattle Glen 3096

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Greensborough 3088 (a small area: Shared with City of Banyule)
- Hurstbridge 3099
- North Warrandyte 3113
- Research 3095
- Wattle Glen 3096

FIGURE 14: NILLUMBIK CLINIC OPENING HOURS AND SUBURBS



	DIAMOND CREEK VIC 3089	DOREEN VIC 3754	ELTHAM NORTH VIC 3095	ELTHAM VIC 3095	DIAMOND CREEK VIC 3089	DOREEN VIC 3754	ELTHAM NORTH VIC 3095	ELTHAM VIC 3095
1-9 hrs	2	0	0	1	2	0		1
10-15 hrs	0	1	1	1	0	1	1	1
16-20 hrs	0	0	0	0	0	0	0	0
21-30 hrs	0	0	0	0	0	0	0	0
31 hrs plus	0	0	0	1	0	0	0	1

Source: EMPHN 2017

Whitehorse - includes the 15 suburbs of:

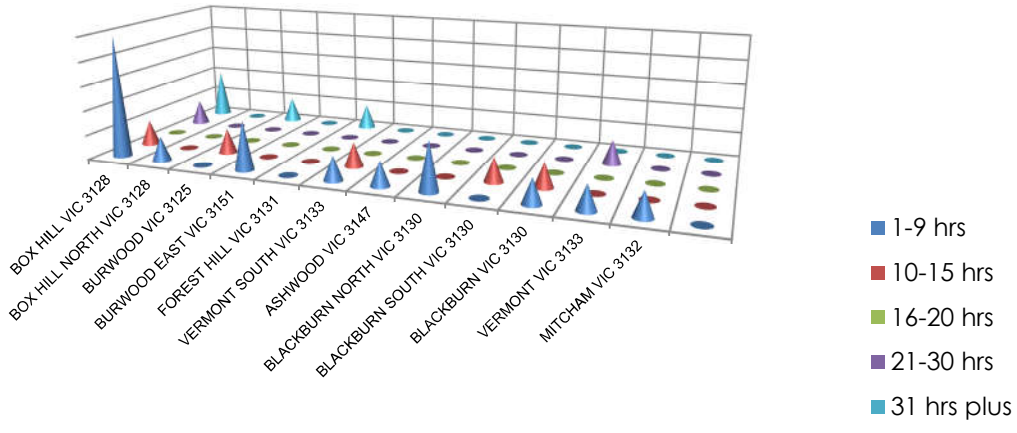
1. Blackburn 3130
2. Blackburn North 3130

3. Blackburn South 3130
4. Box Hill 3128
5. Box Hill North 3129
6. Box Hill South 3128
7. Burwood 3125 (Shared with City of Monash)
8. Burwood East 3151
9. Forest Hill 3131
10. Mitcham 3132
11. Mont Albert 3127 (Shared with City of Boroondara)
12. Nunawading 3131 (Shared with City of Manningham)
13. Surrey Hills 3127 (Shared with City of Boroondara)
14. Vermont 3133
15. Vermont South 3133

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Box Hill South 3128
- Mont Albert 3127 (Shared with City of Boroondara)
- Nunawading 3131 (Shared with City of Manningham)
- Surrey Hills 3127 (Shared with City of Boroondara)

FIGURE 15: WHITEHORSE CLINIC OPENING HOURS AND SUBURBS



	BOX HILL VIC 3128	BOX HILL NORTH VIC 3128	BURWOOD VIC 3125	BURWOOD EAST VIC 3151	FOREST HILL VIC 3131	VERMONT SOUTH VIC 3133	ASHWOOD VIC 3147	BLACKBURN NORTH VIC 3130	BLACKBURN SOUTH VIC 3130	BLACKBURN VIC 3130	VERMONT VIC 3133	MITCHAM VIC 3132	
1-9 hrs	5	1	0	2	0	1	1	2	0	1	1	1	0
10-15 hrs	1	0	1	0	0	1	0	0	1	1	0	0	0
16-20 hrs	0	0	0	0	0	0	0	0	0	0	0	0	0
21-30 hrs	1	0	0	0	0	0	0	0	0	0	1	0	0
31 hrs plus	2	0	1	0	1	0	0	0	0	0	0	0	0

Source: EMPHN 2017

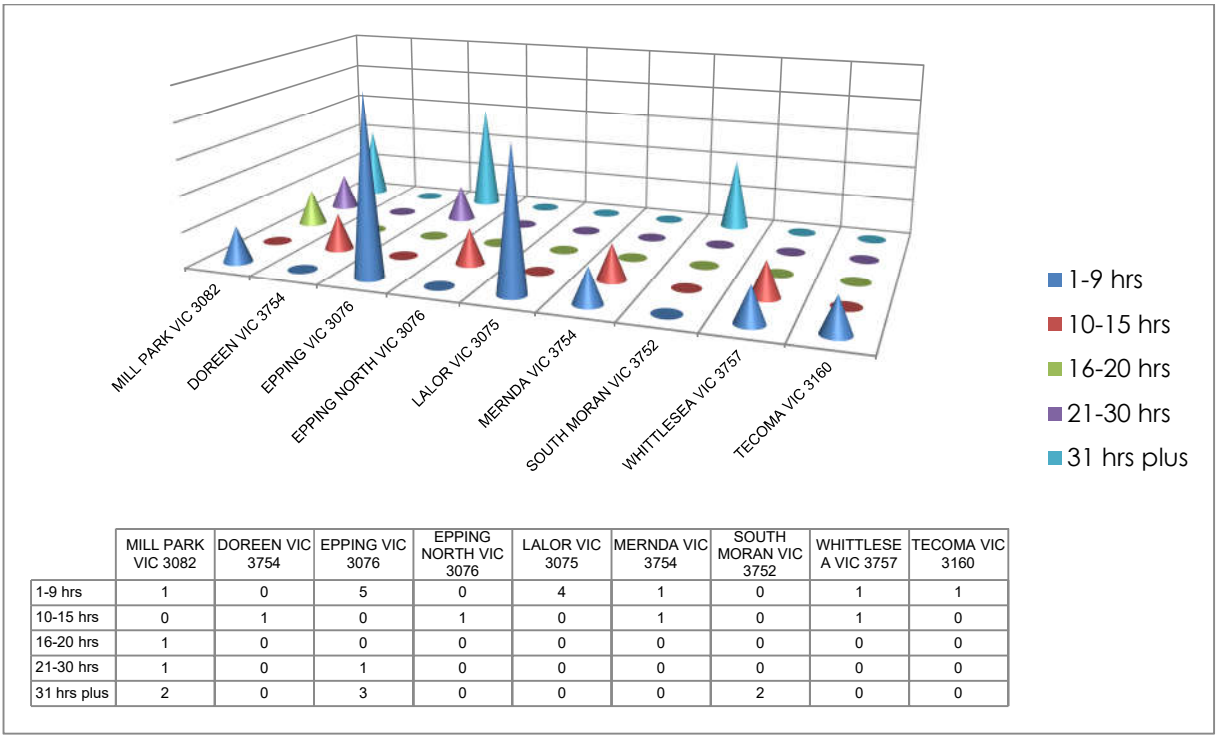
Whittlesea - includes the 8 suburbs of:

1. Bundoora 3083 (Shared with City of Banyule and City of Darebin)
2. Doreen 3754 (Shared with Shire of Nillumbik where it is a rural area)
3. Epping 3076
4. Lalor 3075
5. Mernda 3754
6. Mill Park 3082
7. South Morang 3752
8. Thomastown

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Bundoora 3083 (Shared with City of Banyule and City of Darebin)
- Mill Park 3082
- Thomastown

FIGURE 16: WHITTLESEA CLINIC OPENING HOURS AND SUBURBS



	MILL PARK VIC 3082	DOREEN VIC 3754	EPPING VIC 3076	EPPING NORTH VIC 3076	LALOR VIC 3075	MERNDA VIC 3754	SOUTH MORAN VIC 3752	WHITTLESEA VIC 3757	TECOMA VIC 3160
1-9 hrs	1	0	5	0	4	1	0	1	1
10-15 hrs	0	1	0	1	0	1	0	1	0
16-20 hrs	1	0	0	0	0	0	0	0	0
21-30 hrs	1	0	1	0	0	0	0	0	0
31 hrs plus	2	0	3	0	0	0	2	0	0

Source: EMPHN 2017

Yarra Ranges - includes the 65 suburbs and townships of:

1. Belgrave 3160
2. Belgrave Heights 3160
3. Belgrave South 3160
4. Chirnside Park 3116
5. Kilsyth 3137
6. Lilydale 3140
7. Montrose 3765
8. Mooroolbark 3138
9. Mount Evelyn 3796
10. Selby 3159
11. Tecoma 3160
12. Upper Ferntree Gully 3156 (mainly in the City of Knox)
13. Upwey 3158
14. Badger Creek 3777
15. Beenak 3139
16. Big Pats Creek 3799

Cambarville 3779

17.
18. Chum Creek 3777
19. Healesville
20. Coldstream 3770
21. Dixons Creek 3775
22. Don Valley 3139
23. Fernshaw 3778
24. Ferny Creek 3786
25. Gilderoy 3797
26. Gladysdale 3797
27. Gruyere 3770
28. Healesville 3777
29. Hoddles Creek 3139
30. Kallista 3791
31. Kalorama 3766
32. Launching Place 3139

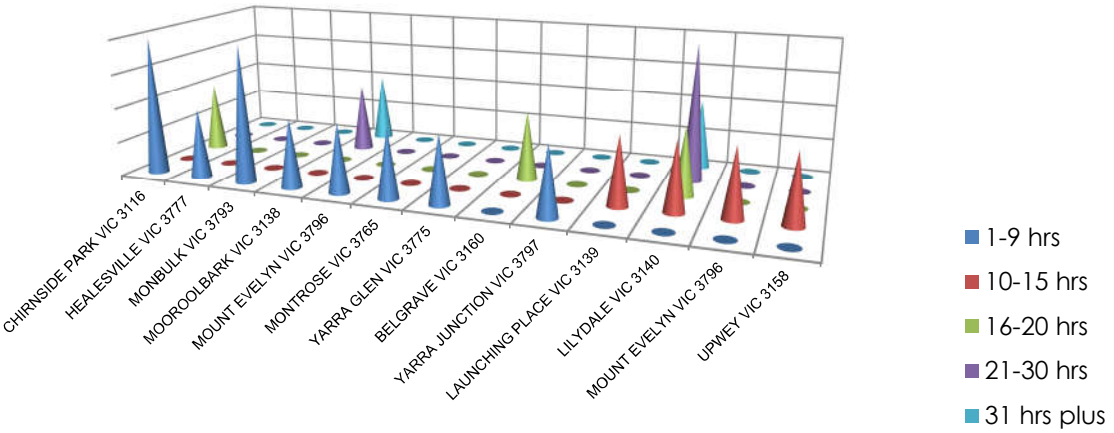
Lysterfield 3156 (shared City of Knox where there is suburban development

33.)
34. Macclesfield 3782
35. McMahons Creek 3799
36. Matlock 3723 (Shared with Shire of Mansfield)
37. Menzies Creek 3159 (Shared with Shire of Cardinia)
38. Millgrove 3799
39. Monbulk 3793
40. Mount Dandenong 3767
41. Mount Toolebewong 3777
42. Narre Warren East 3804
43. Olinda 3788
44. Powelltown 3797
45. Reefton 3799
46. Sassafras 3787
47. Seville 3139
48. Seville East 3139
49. Sherbrooke 3789
50. Silvan 3795
51. Steels Creek 3775
52. Tarrawarra 3775
53. The Patch 3792
54. Three Bridges 3797
55. Toorongo 3833
56. Tremont 3785
57. Wandin East 3139
58. Wandin North 3139
59. Warburton 3799
60. Warburton East 3799
61. Wesburn 3799
62. Yarra Glen 3775
63. Yarra Junction 3797
64. Yellingbo 3139
65. Yering 3770

Within these suburbs the clinics that are open in blocks of hours in specific suburbs are shown in the diagram below. This information shows that clinics are not open in the suburbs of:

- Belgrave Heights 3160
- Belgrave South 3160
- Kilsyth 3137
- Selby 3159
- Tecoma 3160
- Upper Ferntree Gully 3156 (mainly in the City of Knox)
- Badger Creek 3777
- Beenak 3139
- Big Pats Creek 3799
- Cambarville 3779
- Chum Creek 3777
- Coldstream 3770
- Dixons Creek 3775
- Don Valley 3139
- Fernshaw 3778
- Ferny Creek 3786
- Gilderoy 3797
- Gladysdale 3797
- Gruyere 3770
- Hoddles Creek 3139
- Kallista 3791
- Kalorama 3766
- Lysterfield 3156 (shared City of Knox where there is suburban development)
- Macclesfield 3782
- McMahons Creek 3799
- Matlock 3723 (Shared with Shire of Mansfield)
- Menzies Creek 3159 (Shared with Shire of Cardinia)
- Millgrove 3799
- Mount Dandenong 3767
- Mount Toolebewong 3777
- Narre Warren East 3804
- Olinda 3788
- Powelltown 3797
- Reefton 3799
- Sassafras 3787
- Seville 3139
- Seville East 3139
- Sherbrooke 3789
- Silvan 3795
- Steels Creek 3775
- Tarrawarra 3775
- The Patch 3792
- Three Bridges 3797
- Toorongo 3833
- Tremont 3785
- Wandin East 3139
- Wandin North 3139
- Warburton 3799
- Warburton East 3799
- Wesburn 3799
- Yellingbo 3139
- Yering 3770

FIGURE 17: YARRA RANGES CLINIC OPENING HOURS AND SUBURBS



	CHIRNSIDE PARK VIC 3116	HEALESVILLE VIC 3777	MONBULK VIC 3793	MOOROOLBARK VIC 3138	MOUNT EVELYN VIC 3796	MONTROSE VIC 3765	YARRA GLEN VIC 3775	BELGRAVE VIC 3160	YARRA JUNCTION VIC 3797	LAUNCHING PLACE VIC 3139	LILYDALE VIC 3140	MOUNT EVELYN VIC 3796	UPWEY VIC 3158
1-9 hrs	2	1	2	1	1	1	1	0	1	0	0	0	0
10-15 hrs	0	0	0	0	0	0	0	0	0	1	1	1	1
16-20 hrs	1	0	0	0	0	0	0	1	0	0	1	0	0
21-30 hrs	0	0	0	1	0	0	0	0	0	0	2	0	0
31 hrs plus	0	0	0	1	0	0	0	0	0	0	1	0	0

Source: EMPHN 2017

4.5.4 Pharmacies Open after-hours

The table below shows that in 2017 there are 265 Pharmacies in the catchment that open after hours, excluding pharmacies for which data is unavailable or open less than one hour a week. A third of these Pharmacies (85) only open from 1 to 9 hours per week. There are 55 pharmacies that open after hours more than 31 hours per week which includes two pharmacies that are open 24 hours a day. The Unsociable hours on weekdays from 23.00 pm to 7.59 am are the ones with the least coverage.

TABLE 18: AFTER HOURS PHARMACIES OPENING HOURS

After Hours Pharmacies Opening Hours		Sociable Hours Week Days	Unsociable Hours Week Days	Saturday Unsociable Hours	Sunday Unsociable Hours	Total No. of Clinics Open
From 1 to 9 hours per week	No. of Pharmacies Open	15	0	84	26	85
	Total Hours open	66	0	171	82	
	Average hours open	4.4	0.0	2.0	3.2	
From 10 to 15 hours per week	No. of Pharmacies Open	27	0	37	37	37
	Total Hours open	124.5	0	188.5	198.5	
	Average hours open	4.6	0.0	5.1	5.4	
From 16 to 20 hours per week	No. of Pharmacies Open	32	0	31	32	32
	Total Hours open	208	0	157.5	208.5	
	Average hours open	6.5	0.0	5.1	6.5	
From 21 to 30 hours per week	No. of Pharmacies Open	56	0	56	56	56
	Total Hours open	751.5	0	323.5	441	
	Average hours open	13.4	0.0	5.8	7.9	
From 31 hours plus	No. of Pharmacies Open	55.0	51.0	55.0	55.0	55
	Total Hours open	982.5	100	512	691.5	
	Average hours open	17.9	2.0	9.3	12.6	
Total Pharmacies Open After Hours		185.0	51.0	263.0	206.0	265
Total Number of Pharmacies in the catchment						310

Please note: data was not available for 21 pharmacies and public holidays data was excluded as it was unreliable. *Source: EMPHN 2017*

4.5.5 After-hours Helplines

National Health Services Directory

The National Health Services Directory (NHSD) provides easy access to reliable and consistent information about health services (www.nhsd.com.au).

Nurse on call

Nurse on Call is free and available 24 hours a day, 7 days a week. A registered nurse provides health advice over the phone. The website also provides information about health services.

After hours GP helpline

Funded by the Australian Government, after hours GP helpline is free and provides access to a GP at night, on weekends and public holidays (www.healthdirect.gov.au/after-hours-gp-helpline)

Carer Gateway

Carer Gateway is a national service funded by the Australian Government to provide carers with access to practical information and support. Carers include family and friends caring for a family member or friend who has a disability, chronic illness, dementia, mental illness, an addiction or is frail aged (www.carergateway.gov.au).

Pregnancy, Birth and Baby

Pregnancy, Birth and Baby is a national Australian Government funded service providing support and information for expecting parents and parents of children, from birth to 5 years of age. The service is free and provides direct access to a maternal child health nurse on the phone to answer any questions about a child's development or behaviour such as: sleeping, settling, feeding, toilet training and tantrums (www.pregnancybirthbaby.org.au).

MINDHEALTHCONNECT

MINDHEALTHCONNECT is for mental health and wellbeing information, support and services from Australia's leading health providers and supported by the Australian Government (www.mindhealthconnect.org.au).

My Aged Care

My Aged Care is a free phone and online service providing reliable information and access to aged care services throughout Australia (www.myagedcare.gov.au).

5. Literature Review

A rapid literature review of scholarly papers on primary healthcare, including afterhours health care; and PHN after-hours initiatives across Australia identified the following. It should be noted that the EMPHN has already commissioned a number of innovative after-hours services including some in the forms discussed below.

5.1 Mobile Emergency Department

South East Melbourne PHN has provided grants to Atticus Health, Carrum for an after-hours home-visiting service called Mobile Emergency Department On-Call (MEDOC) with facilities and equipment to treat more complex patients.

Primary healthcare has an expanding role in cancer control and palliative care. Healthcare providers are more likely to be available afterhours if they perceive themselves as having a duty of care compared with salaried practitioners who do not reside in the vicinity of the practice. Good communication between specialists and patient's regular healthcare providers are critical for ensuring good patient management, especially for end of life care (Rubin, et al., 2015).

5.2 Coordinated, Integrated and Patient-Centred Systems

Berwick Healthcare, Berwick has forged a partnership with Casey Hospital that will reduce demand on the emergency department during the after-hours period. This project is aimed at educating patients and the community, and building an alliance with other practices within close proximity to deliver high quality primary care during the after-hours period.

Inner South Community Health Service, South Melbourne has initiated a Medical Home project that aims to improve health outcomes in the after-hours period through a range of measures, including: greater clinician availability; ongoing coordination of in-hours care; and, an increase of patient health literacy relating to primary care options during the after-hours period.

First Health Medical Centre – Hampton Park Medical Centre proposes a Holistic Family Care Service Program in recognition that a number of their patients are not responding to care plans and are likely to present to emergency departments. The program will:

- enable families to make appointments to see nursing staff in the after hours period to facilitate tests and assessments
- involve family members to encourage and support each other's health at a personal level

- give patients the opportunity to participate in monthly talks, family nights and group activities

All activities aim to enable patients to work more closely with health providers and specialists.

Adelaide PHN Extended Primary Care in Residential Aged Care Facilities program involves a GP led coordinated multidisciplinary team approach together with capacity and capability building components within residential aged care to improve care and management of residents with complex/chronic conditions and at end of life to reduce avoidable transportation to hospital. Adelaide PHN has commissioned Eldercare Inc., to undertake the project across three sites in Seaford, Glengowrie and Payneham commencing February 2017.

Adelaide PHN After Hours Extension of Mental Health Clinical Services - The after-hours extension of mental health clinical services enables Adelaide PHN commissioned providers of primary mental health care services to provide services in the after-hours period. Selected commissioned providers may provide mental health care services in these hours, adjusted according to population health needs and in agreement with the Adelaide PHN. This flexibility in the provision of primary mental health care services aims to maximise the availability of services during the after-hours period and match service provision to individual need across the region.

Stronger primary care systems result in better health outcomes. Systems are stronger if they are more comprehensive, coordinated, community focused, universal; affordable and family oriented. Medicare provides significant funding to encourage, develop and coordinate better practice in primary care. But recommended care is not always provided and recommended treatment outcomes are often not achieved. Mental illness is often a chronic condition. One in five people report having had a mental disorder in the past 12 months. Each year, about 2,300 people commit suicide. But there is surprisingly little data on the outcomes of primary mental health treatment in Australia (Swerissen, et al., 2016). These findings may inform after-hours healthcare delivery models.

A team-based primary care workforce is emerging. To ensure an adequate supply of this new workforce will require that learners train in practices in which all team members, including nonprofessional staff, have adopted this team-based culture and are well prepared to contribute to patient care individually and as part of a team (Ladden, et al., 2013). This approach may have positive implications for supporting providers to deliver after-hours healthcare.

Adelaide PHN After- Hours Innovation Grants have funded:

- Parkside Family Practice - After hours General Practitioner phone triage for palliative care in RACF; RACF and independent living centre residents; Women's refuge and Boarding School house students.
- Prospect Rd Day Night Clinic - Support with culturally appropriate resources for preventive health clinic aimed at female new arrivals/refugees currently unable to access service in hours.
- Medic-Care - Support to enhance After Hours capacity and provide urgent minor procedural and diagnostic services.

- One Care Medical Centre - Support with extension of clinic and nursing hours to improve targeting of, and access for vulnerable patients, also, support to provide on-call GP telephone triage.
- Trinity Medical Centre - After hours General Practitioner phone triage for vulnerable patients.
- Enhance Occupational Therapy - After Hours Occupational Therapy service; increasing collaboration between Hospital systems, Specialists and GPs

There is no strong evidence that telephone triage improves clinical outcomes, so when the patient's problem is not resolved by the telephone triage, they are likely to attend multiple agencies, including the ED, in an attempt to solve their health problem. The evidence shows that it is likely that these patients would have presented to an ED regardless of the availability of a telephone triage service (Nagree, et al., 2012).

Central Queensland PHN SPOT ON - Supporting Patient Outcomes through Organised Networks Hospital avoidance program aims to ensure patients receive the care they need from the most appropriate clinician in the right place at the right time, every time. The Queensland Ambulance Service, Queensland Health, and GP networks are working together to give patients who call an ambulance, but are deemed suitable to be cared for by a GP, the option of avoiding long waits in the Emergency Department. Members of the community who call an ambulance but do not have a life-threatening illness can be treated by GPs skilled in more acute care presentations. This project is a pilot showing very positive results for patients within the first 12 months. The range of conditions which can be managed within this model is currently being expanded and will be available through Health Pathways in the future.

Darling Downs PHN has funded Telstra Readycare – providing a GP telehealth service throughout the after hours period which is free to residents of the Darling Downs & West Moreton area.

Darling Downs PHN has funded METRO Care Street Crew – will operate in Toowoomba's CBD from 6pm to late on Thursday nights, to identify youths at risk, engage and link them with appropriate community and health services for assistance. All staff and volunteers administering the program have front line mental health training which includes accidental counselling, suicide/self-harm intervention and youth mental first aid.

Central and Eastern Sydney PHN is funding the CAN Mental Health After Hours Support Line. CAN Mental Health is a not-for-profit organisation championing recovery for mental health consumers. This project will establish a peer run support service that will provide an after-hours telephone support line to CESPHN residents experiencing psychological distress.

South Western Sydney PHN funds the After Hours GP helpline. The After Hours GP Helpline is for people who have limited access to face-to-face GP services in the after hours period, people who have a health concern and require the advice of a GP, who don't know where to access after- hours care and who are not sure what they should do about their health concern. Recent changes to the GP Helpline include transitioning to an outbound call model where callers are offered a call-back from a GP and a more targeted service for areas where there are limited face-to-face after hours GP services.

Northern Sydney PHN Emergency+ Smartphone App Australia's Triple Zero Awareness Working Group has developed a smartphone app for iOS, Android and Windows devices to:

- Provide the caller with information about when to call Triple Zero
- Provide the caller with information about who to call in various non-emergency situations
    - State Emergency Service (SES) (132 500)
    - Police Assistance Line (131 444)
    - Crime Stoppers (1800 333 000)
    - Health Direct Australia (1800 022 222)
    - National Relay Service
- Assist the caller to dial the relevant number.
- Display the GPS coordinates of the phone's location that the caller can read out to the emergency operator.

The app is free of charge and available for download from iTunes, Google Play and Windows Stores.

5.3 Home Based Care

South East Palliative Care will develop and launch a Carer Support Kit into the SEMPHN community to support clients at home particularly during the AH period when access to health services is limited.

Several home-based primary care programs have emerged across the United States that are characterized by common principles: 1) medical house calls are made by the ongoing primary care provider (physician or nurse practitioner); 2) the primary care provider leads an inter professional care team; and 3) the program is
available after hours for urgent issues. Many of these programs also have access to or the capability to perform home-based laboratory and diagnostic imaging services. Several leading medical centres have developed academic home-based primary care programs, with several reporting impressive outcomes such as substantial reductions in emergency department visits, hospitalizations, and long-term care admissions.

The largest proponent and most successful provider of home-based primary care has been the Veterans Health Administration in the United States. In the mid- 1990s, a concerted effort to shift the focus and delivery of veterans' care to outpatient primary care models was pursued. This important transformation was made with the foresight that older veterans would be poorly served by a health care system that was becoming increasingly reliant on inpatient and acute care models. In 1995, the Veterans Affairs System established its home-based primary care programs with the intent to deliver longitudinal comprehensive primary care in the home. These programs currently care for approximately 25 000 veterans across the United States, and have demonstrated the ability to achieve good patient, caregiver, and systems-level outcomes. Emerging evidence from the Veterans Affairs System has reported considerable improvements in patient quality of life and caregiver satisfaction, as well as reductions in emergency department visits, hospitalizations, readmissions, and long-term care admissions.

Recognizing the success of these programs, the most recent US health care reform legislation—the Patient Protection and Affordable Care Act of 2010—included a provision to test a remuneration incentive and operational model for home-based primary care, known as the Independence at Home program. This

demonstration program is adopting the core standards that characterize other successful US programs, including using physician- or nurse practitioner–led teams who are available 24 hours a day, 7 days a week. This demonstration program aims to reduce emergency department visits and avoidable hospitalizations and readmissions, improve patient outcomes, and reduce health care costs (Stall, et al., 2013).

5.4 E HEALTH TECHNOLOGY

Tasmania PHN has funded GP2U Telehealth to pilot a unique statewide after hours telephone support service to improve access to care for vulnerable people experiencing urgent mental distress.

In Canada, improved access to specialist care and decreased wait times in a region was achieved through the development and implementation of the Champlain BASE (Building Access to Specialists through **eConsultation**) service. This secure, web-based tool allows primary care providers quick access to specialist advice for their patients and often helps to avoid the need for a face-to-face referral. The successful implementation of eConsult in region provided a unique opportunity to examine provider's satisfaction and overall perspective on using the service. There was a high level of satisfaction with eConsult's quick turnaround time and quality of specialist advice. The results illustrate the advantages of using asynchronous virtual platforms to increase access to specialty care from a provider's perspective (Liddy & Drosinis, 2015). This may have positive application to the delivery of after-hours healthcare.

Patients with low socioeconomic status (SES) use more acute hospital care and less primary care than patients with high socioeconomic status. This low-value pattern of care use is harmful to these patients' health and costly to the health care system. Two categories of patients were studied: Profile A patients who described that experiences with early-life trauma had profound implications on their sense of well-being throughout adulthood. Profile A patients were more likely to explain their illnesses as a result of a stepwise progression of family dysfunction, substance abuse, housing instability, and ultimately disability leading to difficulty with activities of daily living. Profile B patients had similar income, sex distribution, race, and neighbourhood characteristics as Profile A patients. But in contrast with Profile A patients, Profile B patients described a functional social network that provided emotional support. Both profile subtypes used easier access and higher technical quality as rationales for preferentially using hospital over ambulatory care. However, Profile A patients explained an additional set of drivers uniquely related to the safety-net role that the hospital played in their lives, e.g. for social and emotional contact. Primary healthcare providers (including after-hours providers) need to be more responsive to the needs of SES patients in order to reduce hospital presentations (Kangovi, et al., 2013). This research supports the need to provide mental health after-hours healthcare and support systems.

Little high-quality evidence was found on the interventions considered in this review, that is, telephone triage systems, in- or 'out-of-hours' primary care provision and GP cooperatives, community health centres, walk-in clinics, minor injuries units, and urgent care centres; and no conclusive evidence was found to suggest that any of the interventions consistently reduce A&E attendance rates. Findings from this review reinforce the idea that patient behaviour is an important determinant of emergency department attendance (Gibbons & Gnani, 2013). This study suggests further research into patient after-hours healthcare behaviour.

Among people who tried to contact their regular primary care provider after hours for a medical need, those with greater ease of access had significantly lower rates of emergency department use and unmet medical need, even after the overall coordination of their primary care was controlled for. Increased support for primary care practices to provide or arrange for accessible after-hours care (by phone, by e-mail, or in person) has the potential to reduce rates of emergency department use and unmet medical need (O'Malley, 2013).

5.5 Health Literacy and Information

The North Western Melbourne PHN is addressing health literacy issues in its region in the following ways:

1. Improving staff knowledge of health literacy as an enabler to improving health care outcomes, and increase staff capacity to incorporate health literacy actions into their program work.
2. Supporting general practices and other primary health care providers in understanding health literacy and its impact on health care outcomes, including evaluating the current status of their practice in how it helps/hinders health literacy, and undertaking training and practical quality improvement activities that can be undertaken to improve the health literacy environment of their practice.
3. Improving the health literacy of priority populations with additional health literacy burden such as Aboriginal and Torres Strait Islander people, people with low educational attainment, refugees and 38 asylum seekers, and communities that speak English as a second language.
4. Collaborating with strategic partners including universities , Primary Care Partnerships, the Health Issues Centre, the Centre for Culture, Ethnicity and Health, the Department of Health and Human Services and others, on health literacy workforce training/development and consumer engagement initiatives in the region.

RDNS Homecare, SEMPHN-wide initiative involves the RDNS working with targeted residential aged care facilities to build the health literacy of staff, particularly as this relates to accessing primary care services during the after-hours period. Ultimately, this project will support RACF staff to make more informed decisions relating to accessing primary care during the after-hours period.

National Home Doctors Service, SEMPHN-wide initiative will involve a Town Hall Health Literacy education program, focusing on maternal and paediatric health. This project is designed to support parents of young children to better understand and engage with urgent care responses for their children, with the intention of reducing presentations of this cohort to emergency departments during the after-hours period.

Genesis Medical Centre is developing and implementing a psychological education and health literacy program for people living with drug addiction and their families.

Hero Head Quarters in recognition that a large majority of primary care-type visits are attributed to the 0-4 age group, this activity will aim to improve the health literacy among parents and caregivers of children in this age bracket. The activity involves training to empower parents and caregivers in the region to:

- educate parents with self-triage skills and take appropriate action depending on the child's conditions;
- build knowledge of AH services in the community; and
- build their skills and confidence.

Physicians need to be cognizant of the finding that a significant number of parents bringing their children to the ED have low health literacy. These physicians may need to adapt communication strategies and include low literacy strategies, such as the teach-back method and incorporation of health literacy–related education materials into ED discharge materials. Situations with high clinical demand likely exacerbate low parent health literacy (e.g., providing incorrect doses of asthma medications), whereas parents of otherwise healthy children may not have a challenge to their ability to obtain, process, and use health information. Approximately 1 in 3 parents seeking care with their children at the ED have low health literacy, limiting their ability to process, understand, and make medical decisions for their children. A potential relationship exists between low health literacy and increased emergency department utilization. Low literacy interventions targeted at parents likely to have low health literacy seem to result in decreased ED utilization. However, a clear gap in the literature exists: there are no published interventions targeted specifically at parents with known low health literacy. Applying targeted or population-based health literacy related educational interventions has the potential to reduce repeat ED visits, reduce health care expenditures, and narrow the health disparities gap by empowering parents with low health literacy to obtain appropriate care for their child (Morrison, et al., 2013) .

Adelaide PHN is developing an After Hours Consumer Awareness Resource which proposes a range of solutions to ensure that residents in the Adelaide PHN region will have access to, or information regarding, appropriate and accessible after-hours primary care services. A key element will include the provision of consumer information offering advice such as: Emergency Department triage of symptoms, determining the most appropriate care available in the after-hours period and information enabling access to affordable care. The two elements to the project include a hard copy flip chart for Playford City Council residents (early 2017) and a mobile optimised website for the entire Adelaide metropolitan region (mid-2017).

Brisbane North PHN will this week re-launch the Emergency Alternatives emergency department (ED) avoidance advertising campaign, building on the success of the campaign during winter last year. A survey of 300 people following the 2016 campaign showed that seven in ten (77 per cent) now understand there are a number of alternatives for medical help after hours. Brisbane North PHN Chief Executive Abbe Anderson said the Emergency Alternatives campaign had resonated with people on a cognitive level, with many heeding the message that the emergency department was not always the best option. To visit the campaign website, go to www.emergencyalternatives.org.au.

Brisbane South PHN Homeless to Home Healthcare After- Hours Service is part of an integrated multi-disciplinary outreach team operating 7 days per week 5pm – 11pm. Each night two teams that include a registered nurse and a Street to Home outreach worker deliver health and housing support to people who are rough sleeping and to those who have made a transition from homelessness to housing, but who require ongoing and consistent social support and healthcare. Health services include:

- health assessments.

- direct nursing interventions including assistance with medication, wound care, health education, mental health support.
- referral to emergency, primary health and allied health services.
- collaboration with Street to Home Community Health Nurse and Home for Good Clinical Nurse and Pathways Nurses.

The Community Response to Hospital Emergency Departments (ED) works with vulnerable individuals who present frequently to emergency department to:

- reduce the number of unnecessary presentations to Emergency Departments at the Royal Brisbane and Women's Hospital (RBWH) and The Prince Charles Hospital (TPCH) through the provision of a targeted community health, housing and social connection response
- facilitate communication across stakeholders that encourages collaboration and problem solving to improve service system responses and quality of life outcomes for the individual.

A Clinical and Credentialed Mental Health Nurse and a Support and Advocacy Worker aligned with the Home for Good Coordinated Access and Referral team provide care coordination and intensive case management to build the person's capacity to self-manage their health and wellbeing. This includes:

- assistance and support to access and maintain stable accommodation
- linkage with primary care and specialist health services
- developing an integrated community support network
- developing self-management strategies to manage their mental and physical health.

Darling Downs PHN has funded AH Diabetes – The DDWMPHN, in conjunction with AH Diabetes has established an After Hours service offering support and education to people managing diabetes, running from February to 30 June 2017. Clients will be able to phone or drop in to get advice from a Diabetes Educator to assist in the treatment and management of this condition.

Nepean Blue Mountains PHN After Hours Information Toolkit is a range of FREE materials available for local general practices to order/download for use with their patients. They are designed to raise awareness locally of the after hours medical services available and how to use them appropriately, as many local residents are unaware that there are after hours services in the Penrith, Hawkesbury and Lower Mountains areas, which can result in unnecessary attendance at an emergency department for non-emergency situations.

6. Consultations with Key Informants

The findings of a rapid consultation conducted with key informants – *see Appendix 1* – reiterated previously identified key issues impacting after-hours healthcare access and utilisation and included suggestions for improvements. The findings of the consultations have been thematically categorised as follows:

6.1.1 General access to afterhours healthcare and Service provision

Key issues

- Consultations with stakeholders reiterate that after-hours access to GPs, pharmacies and other healthcare services is variable across the EMPHN catchment with some geographic areas lacking after-hours services altogether. After-hours service provision also remains a challenge in the outer east where it is difficult to provide enough coverage given the distances involved (consultations with Community Advisory Committee).
- Telehealth and video conferencing was identified by many as a key enabler of improved after-hours provision. However direct patient to GP telehealth does not attract a Medicare rebate and is privately billed thus limiting the capacity of general practice to provide teleconsults at any time (consultations with forum participants).
- The latest version of 'My Health Record' promises to be user friendly and increase connectivity between practitioners/services e.g. hospitals across all types of healthcare services and 24 hours 365 days (consultations with forum participants).
- It was also reported that after-hours pharmacy, mobile radiology and pathology services are needed to ensure patients get appropriate intervention, treatment and medication promptly; as an alternative to receiving these services in hospital emergency departments (consultation with Nillumbik and Research Medical Centre). However, consultations with forum participants also highlighted that these services are most effective when specialist are available to provide test results after-hours.

The demand for after-hours healthcare is demonstrated in the example of the Laurimar Medical Practice in Whittlesea which operates until 7pm and is constantly booked. The practice has implemented an initiative to provide a fracture clinic including x-rays operating until 9pm. Further, the Mooroolbark Super Clinic is open until midnight, often with four Doctors, and usually fully booked (consultation with Nillumbik and Research Medical Centre and Moorollbark Superclinic)

- It was reported that families with young children were more likely to go directly to a hospital emergency department; and more likely to call an MDS than Nurse on Call or equivalent service. Fractures and falls, gastro-intestinal conditions, upper respiratory infections and unexplained rashes were identified as common reasons parents sought after-hours healthcare for their children (MDSs, Ambulance Victoria)

- Informants advised that information about after-hours pathways to health care needs to be clearly mapped out so that patients, their relatives and practitioners understand what is available and how to use it (consultation with MDS).
- MDSs and GP clinics also reported that they have difficulties recruiting doctors to work after-hours because MBS billing (and gap fees if they are charged) is insufficient to attract the workforce (either on a remuneration or billings basis). For example, MDSs stated that doctors wanted an assurance that they would see a minimum of two patients per hour for it to be worth their while. MDSs are 'meant' to have a two hour wait time. However, they are often already fully booked by 9.00 p.m., meaning patients will then go to ED. It was also noted that the 5.00 am – 8.00 am period was particularly difficult to staff (consultations with forum participants, GP clinics and MDSs).
- GP clinics have reported that it is financially very difficult to provide after-hours healthcare. While bulkbilling can be provided during business hours, a gap fee is charged by many clinics operating after-hours which appears to be prohibitive for some members of the community. The Nillumbik Clinic in Eltham trialled opening on weekends charging a gap fee to cover additional costs; and concluded from patient behaviour and feedback that patients were not willing to pay the gap fee so they ceased operating on the weekends. The clinic indicated that more GPs need to be willing to work after-hours and that they probably need to be on a retainer with nursing support in for them to be interested. They also highlighted regulatory systemic difficulties that prevent it from providing after-hours care to aged care facility residents, despite having experience and skills in this area (to do with qualifying as a MDS) (consultation with Nillumbik and Research Medical Centre).
- MDSs have difficulties covering some geographic areas due to GP shortages - it was explained that this situation will change as the population in these areas grows (consultations with MDSs).
- It was reported that overseas trained GPs who work in accordance with District of Workforce Shortage (DWS) restricted licence regulations are often unfamiliar with the Australian healthcare system, have low level English language proficiency, have not been fully trained is specific areas, e.g. fractures; and are often unsupervised and unsupported. Both members of the community and healthcare practitioners have indicated concerns about the capabilities of overseas trained GPs working in GP clinics and MDSs. Concerns were also raised more generally about GPs with limited skills and experience willing to work after-hours due to the stress of GP work and because many younger GPs have families with young children that they want to spend more time with. Conversely many older GPs are tired and not willing to work after-hours (consultation with Nillumbik and Research Medical Centre).
- Lack of travel options for people living in Yarra Valley were identified (consultations with CAC).
- The Northern ML had provided some funding for a police, ambulance and clinical early response (PACER) program where a psychologist attended mental health crises with police to provide a more appropriate service system response and to reduce unnecessary admissions to emergency departments. This was seen as an important initiative that should be continued (consultation with Community Advisory Committee).
- Access to pharmacies after-hours varies across the catchment and it was reported that some outer suburbs have limited options (consultation with the CAC).

- The National Health Services Directory was identified as a potentially useful resource with information about after-hours healthcare however, it was reported that 40% of the directory's content is inaccurate.

Suggested Improvements

- A deputising service called for the redirection of funding from the current incentivisation for volume of calls, to supporting contractual relationships with GP's. There was also a view that the recent growth in deputising services was in part a result of entrepreneurs entering the market to take advantage of higher value Medicare rebates. Deputising services reported that as many as 30% of their patients don't have a regular GP and that they actively encourage these patients to link with a local GP. The need for additional funding to increase after-hours service provision and cover geographic areas with limited after-hours options was highlighted (consultations with MDSs).
- In spite of the lack of Medicare support for direct patient to GP telehealth, key informants encouraged the exploration and extension of telehealth strategies in all relevant programs to enhance tri-age services and enable early responses, e.g. in pharmacies, to reduce escalation to after-hours services with follow up in-hours (consultations with Eastern Health RIR, Pharmacist, Ambulance Victoria and both Forums).
- The availability of radiology and pathology services after-hours was raised and it was suggested that there should be further piloting of after-hours mobile radiology and pathology services (consultations with Monash and St Vincent's RIR). Note: the EMPHN is working to determine demand and availability of ancillary services such as Radiology and Pathology during the after-hours period, and commission additional afterhours services where appropriate (EMPHN, 2016).
- Some Community Health Services provide after-hours healthcare including allied health, dentistry and GP. It was suggested that options for Community Health Services extending their opening hours for targeted allied health services should be explored (consultations with Carrington Health and EMPHN Mental Health Team).
- Increasing the use of Nurse on Call by the general community, including extending it to video calling, was identified as important, for example, nurses being able to calm callers who are anxious, especially parents with young children. Liability issues that may limit the level of advice offered by nurses over the phone need to be addressed (consultations with Eastern Health RIR, the CAC and MDS service).
- To reduce emergency department workloads at Maroondah Hospital, it was suggested that a 24 hour clinic should be provided at the hospital (consultations with Eastern Health RIR; Mooroolbark Super Clinic; Northern Health and RIR).
- The possible development of an App to provide details on after-hours services was proposed (consultations with Monash RIR, CAC and the EMPHN Mental Health Team).
- It was suggested that funded training on using apps, tele and video conferencing etc would be very useful in extending service options (consultations with forum participants)

- The EMPHN GP Engagement team indicated that GPs could benefit from funding support for GP recruitment activities. For example, some recruitment companies can charge as much as $18,000 to recruit GPs and many clinics shy away from paying this, instead trying to recruit through their networks which is not always very successful (consultations with EMPHN GP Engagement Team).
- Funding deputising services based on their relationships with GPs and agreed referral pathways and thresholds that clearly recognised their respective role, was suggested as a strategy for building relationships between GPs and deputising services rather than fund them based on the number of calls (MDS).
- The GP Engagement Team continue and accelerate engagement with GP after-hours services in order to determine how it can add value to after-hours healthcare system and encourage GPs to participate in EMPHN activities (consultations with EMPHN GP Engagement Team).
- The pharmacists consulted generated some suggestions including exploring ways in which the educational and prevention/early intervention role of pharmacists can be enhanced particularly as all provide some degree of after hours service (consultations with Pharmacist on EMPHN Clinical Council and Pharmacy participants at Forum No 2).
- Explore options for increasing after-hours pharmacy access and build on the current funding to a number of pharmacies to extend their opening hours and services provided (consultations with Pharmacy participants at Forum No 2).

6.1.2 People with a disability

Key issues

- Health professionals, including those providing afterhours healthcare do not have sufficient knowledge and skills in treating people with a disability (consultation with forum participants).

Suggested Improvements

- Provide training to GPs and other health professionals on working with people with disability (consultation with forum participants).

6.1.3 People with AOD issues

Key issues

- Patients presenting with alcohol issues (including after hours) are a major concern for emergency departments (consultations with EMPHN Mental Health Team, St Vincent's Hospital RIR).

- Pharmacists stated that there is insufficient resourcing of the methadone program which ultimately impacts on the success of the program. Many pharmacies only see the methadone program as a source of income and are not interested in being flexible. Incentives for after-hours services could have a positive impact on methadone patients (Pharmacy participants at Forum No 2).

Suggested Improvements

- MyHealthRecord will also be useful for pharmacists who can more easily monitor patient drug use to particularly identify patterns of potentially harmful use, e.g. AOD issues (consultations with EMPHN).

6.1.4 People with Mental Health Issues

Key issues

- Access to after-hours services for people with mental health issues was identified as a key gap in the current system. After-hours services tend to be provided by the CAT Team and emergency department, which may not always have a mental health nurse or psychiatrist available (consultations with Community Advisory Committee and forum participants).
- Ambulance Victoria is currently involved in a trial with Outcome Health which features a mental health nurse being available for specific callouts. They advised that the service involved telephone triage and side by side coaching to build knowledge as to how to respond to mental health needs and a better understanding of the mental health service landscape, language, and key relationships. The intention is to provide a more appropriate response, minimise non-critical ambulance call outs and emergency presentations and provide capacity building (consultation with Ambulance Victoria).
- The CATT team provides a 24 hour service however the criteria used to determine who the team should respond to means that in some cases the CATT team does not respond to some requests leaving referrers and families perplexed about the role of the CATT team (consultations with Community Advisory Committee).

Suggested Improvements

- Consider expansion of the Ambulance Victoria-mental health nurse liaison service (consultations with the EMPHN Mental Health Team). Advocate upskilling of GPs on mental health
- There is a need to incentivise GPs to take an interest in mental health; An option is to bring back/trial a call line after hours to a psychiatrist (consultations with EMPHN Mental Health Team)

6.1.5 Aged Care– RACF's and RIR Services

Key Issues

- After-hours healthcare for aged care facility residents can be problematic. Often there are long waits for GPs; or Ambulance Victoria is called upon when the patient's issue could be addressed by a GP or other healthcare practitioner. In some instances the residential facility's policy and direction to staff is to call an ambulance rather than seeking another alternative. There is limited ability for RACF staff to respond in an emergency and as a consequence, some residents are referred directly to the emergency department rather than accessing after hours GPs (consultations with Nilumbik research and medical; and forum participants).
- Pharmacists are expected to bring medications to RACF residents when doctors who prescribe them arrive late – this service is effectively 'invisible' and not funded. The view was that this has come to a critical point, alongside ongoing cost pressures, where the service is unsustainable representing a harmful financial and emotional burden on Pharmacists. Factors such as residents' preference for their GP, GP reluctance to come to facilities, consequent delays in prescribing medication, overtreatment and medico-legal fears amongst aged care staff, all contribute to avoidable ambulance call outs and emergency presentations (Pharmacy participants at Forum No 2).
- It was reported that there is significant variation in the skill levels of staff at Residential Care facilities and some facilities only have their registered nurses on call, often relying on young and inexperienced staff (consultations with forum participants)
- Much better liaison is needed between Deputising Services, GPs, and facilities. St Vincent's see Deputising Services as aggressive in their approach, i.e. they do not always work in the interests of the patient. The two Deputising Services consulted drew a distinction between that approach and a different approach based on established formal relationships/partnerships with in-hours GP's, that respects their role and has clear agreements for referral to and from GP's and RACF's (consultations with St Vincent's RIR; Northern Health and RIR, forum participants and MDSs).

Suggested Improvements

- The view was expressed that there is a need for regulatory change to require residential aged care facilities to have access to an impress. This proactive approach would ensure that the facility had adequate supplies of properly prescribed medication rather than calling an after-hours GP to come to the facility every time the medication ran out. This would have to be subject to regular medical review but this could be planned in hours with the resident's regular GP or the facility's in-hours GP. The pharmacist consulted took the view that they could pay the licencing fee but the facility would need to take the medico-legal responsibility to house antibiotics etc. and put in place proper security and safety measures (consultation with pharmacist on the EMPHN clinical council; pharmacists who participated in forum 2).

- Work with RACFss to develop better systems and practices in-hours for the review of medications and secure storage of drugs, which could lead to better in-hours provision and improved decision making. Where such interventions occurred, staff would have the confidence and supply needed to respond in a timely manner rather than allow situations to escalate to after-hours (consultations with MDS service, Pharmacist)
- Develop guidelines/protocols, for example, in relation to palliative care, with aged care facilities to direct workers on when to use the different after-hours healthcare options available in order to reduce unnecessary ambulance callouts and resident hospitalisations (consultations with forum participants).
- Investigate and/or advocate for a dis-incentivisation program targeted at aged care facilities to reduce inappropriate ambulance calls and emergency department presentations (consultations with forum participants).
- Undertake a project to audit and then expand the quantity and quality of Advanced Care Plans, which are often absent, incomplete or of poor quality. Use these Plans to facilitate healthy discussions between families about appropriate responses to deteriorating health of family members, and then between family members and the facility (consultations with Austin Health ACP Team).
- Link Advanced Care Plans with 'My Health Record' (consultations with Eastern Health RIR; Austin ECP Team Leader); the key being to strengthen/upskill consumers, GPs and Practice nurses and RACFs staff on Advanced Care Plans
- It was suggested that the EMPHN take up an advocacy role to attain a Medicare number for Advanced Care Plans (consultations with Monash RIR; St Vincent's GP Liaison; Austin Health RIR; St Vincent's RIR; Northern Health, RIR)
- Explore options for expanding the RIR services to include SRSs where older people and people with a disability may live (consultations with Austin Health RIR and EMPHN Mental Health Team).
- Establish bi-monthly meetings with facility managers to improve communication, share information and knowledge, and encourage appropriate responses to patient requirements (consultations with Austin Health RIR).

6.1.6 Health Literacy

Key issues

- The need for community awareness and education continues be a priority in order for people to understand the suite of after-hours options are available and how to access them. It was reported that in many cases people don't know about healthcare services available after-hours and when is appropriate to use them, instead calling and ambulance and/or presenting at a hospital emergency department as the default action. This issue is exacerbated in areas where there are few or no services after-hours, including MDSs and particularly when children are involved and parents are anxious about

making the right decision (consultation with Community Advisory Committee, Ambulance Victoria, MDS's and Forums).

- Some clinics, such as Nillumbik, who provide after-hours healthcare, reported that despite marketing campaigns they were surprised at the lack of awareness of their services by the general community (consultation with Nillumbik and Research Medical Centre).
- In relation to medication a pharmacist made the point that people make errors regarding their medications all the time, are sometimes reluctant to pay the $5 fee for Pharmacy to make up packs via the Dose Admin Aid Scheme and that there is not a huge uptake of the MedsCheck Program funded by Medicare. It was reported that people still defer to their GP regarding medication even though medication reviews are not done a lot as doctors have limited training about drugs. They also tend to assume patients take them properly. Avoidable after-hours demand is often a consequence (consultation with pharmacists who participated in forum 2).
- In the case of families with young children, according to respondents, there appears to be a prevailing perception that the Royal Children's Hospital should be the first port of call for all healthcare issues for children (consultations with forum participants).

Suggested Improvements

- Work with community leaders who have greater access to hard-to-reach groups, for example, CALD community, was identified as an important activity for raising community awareness of after-hours services. Nilumbik GP clinic stated that they provided medical assessment for refugees settled in Eltham however the government funding provided for this purpose has not been sufficient. This clinic also identified the importance of orientating refugees to the Australian Healthcare System including after-hours healthcare (consultation with Nillumbik and Research Medical Centre).
- EMPHN advocate for a Medicare item number to provide health literacy and health education, for example, for the development of a health literacy plan; including an information pack and dialogue to educate patients. The EMPHN could develop the information pack. It was suggested that if there was a Medicare item number for health literacy then services could bill for spending time with patients educating them about after-hours healthcare. It was recommended that nurses should have this role (consultations with Nillumbik and Research Medical Centre).
- Liaise with VICHEALTH to access expertise in designing effective, evidence-based health promotion campaigns to increase community awareness (consultations - the need for greater community awareness and improved health literacy was emphasised in virtually every consultation, MDS, participants at each Forum, Pharmacists, Ambulance Victoria. Eastern Health RIR also pushed this, but feared over promotion and therefore unable to cope with demand; St Vincent's RIR).
- Reference was also made to a Queensland information campaign where a letter-dropped pamphlet provided a traffic light approach to guide people on which after-hours services they should access depending on the presenting issue. The view was put that such strategies are likely to be more effective than awareness raising campaigns that attempt to change community behaviour regarding the appropriate use of ambulances. Citing the experience of such campaigns in the UK, Ambulance Victoria

noted that instead of minimising ambulance call-outs and emergency department presentations, counter-intuitively, they often have the opposite result (Ambulance Victoria, consultations with participants at forum No. 1).

- Establish small and effective working groups led by community leaders to engage with their local community to raise community awareness about after-hours services and health literacy (consultations with Monash RIR, CAC and the EMPHN Mental Health Team).

6.1.7 Workforce Issues

Key Issues

- MDSs and GP clinics reported that they have difficulties recruiting doctors to work after-hours because MBS billing (and gap fees if they are charged) is insufficient to attract the workforce (either on a remuneration or billings basis). For example, MDSs stated that doctors wanted an assurance that they would see a minimum of two patients per hour for it to be worth their while. MDSs are 'meant' to have a two hour wait time. However, they are often already fully booked by 9.00 p.m., meaning patients will then go to ED. It was also noted that the 5.00 am – 8.00 am period was particularly difficult to staff (consultations with forum participants, GP clinics and MDSs).
- The EMPHN GP Engagement team indicated that it has been difficult getting GPs to attend information forums, training and meetings and is constantly plugging away at engaging with GPs. However, the team also indicated that they have not specifically targeted after-hours GPs as this requires engaging with them after-hours (consultation with EMPHN GP Engagement Team).
- Consultations indicated that in many instances practitioners are not familiar with the range of after-hours healthcare services and that they would benefit from ongoing awareness and education activities (consultations with MDSs, Forums 1 and 2)

Suggested Improvements

- Improved education as to how GP's could maximise the value of after-hours services noting that many Deputising Service business models provided limited scope to do this given there usually are a small number of people 'supervising' a large number of doctors (consultations with MDSs).
- Running forums comprising small groups of health practitioners to share information about after-hours healthcare was also suggested. It was emphasised that it is difficult to bring practitioners together so careful planning is required to ensure forums are relevant, engaging and ultimately beneficial to participants. Further, it was suggested that this type of activity to practitioners could be linked to accreditation - including standards for patient outcomes. This should also include indicators for health literacy so that practitioners can be accredited against the standards as part of their professional development requirements, thus providing an incentive for practitioners to attend forums.

- Engagement with after-hours GP's by the EMPHN Engagement Team would benefit relationships with after-hours GPs. Deputising Services who have formal after-hours arrangements with GP's indicated a preparedness to assist with this work (consultation with EMPHN Engagement Team).
- Help practitioners inform their patients about after-hours healthcare options and when to use them including the value of clearer guidance about options and contact details via answering services and information on clinic doors when closed (consultations with EMPHN Mental Health Team, MDS service)
- When the Medicare Local had a laminated flow chart with mental health services that GPs could refer to, the GPs feedback was that they loved it because it provided health pathways at a glance. The EMPHN Mental Health team is investigating this initiative at present (consultation with EMPHN GP Engagement Team).
- EMPHN develop an information pack as a resource for practitioners (GPs, nurses, aged care workers etc.) to build practitioners knowledge about after-hours health care options and utilisation (consultations with St Vincent's RIR).

6.1.8 INTEGRATED SERVICES

Key issues

- The lack of integration across services was identified as a key issue, i.e. greater collaboration across key services such as ambulance, hospitals, deputising services and pharmacies after-hours was considered important for maximising efficiencies across the service system. Achieving greater cohesion across the spectrum of services provided after-hours was identified as a priority (consultations with forum participants).
- The need for much better liaison between Deputising Services, GPs, and facilities was highlighted. St Vincent's see Deputising Services as aggressive in their approach, i.e. they do not always work in the interests of the patient. The two Deputising Services consulted drew a distinction between that approach and a different approach based on established formal relationships/partnerships with in-hours GP's, that respects their role and has clear agreements for referral to and from GP's and RACF's (consultations with St Vincent's RIR; Northern Health and RIR, forum participants).

Suggested Improvements

- Develop joint projects with pharmacies to implement after-hours healthcare strategies (consultations with Pharmacist on EMPHN Clinical Council and Pharmacy participants at Forum No 2).
- The EMPHN GP Engagement Team to increase their role in building communication and engagement between the Medical Deputising Services and GPs.
- In the long-term, it was reported that the current funding model should be reviewed and changed as stakeholder incentives/self-interest impede improvements to the system. With particular reference to

aged care facilities, it was suggested that consideration should be given to how to mandate practitioners to follow procedures that can reduce inappropriate emergency department presentations (consultations with forum participants).

6.1.9 Emergency Departments

Key Issues

- All informants identified the use of emergency departments for non- urgent care as a key issue and highlighted the need to reduce this so it is able to properly perform its role of providing emergency care.
- All informants generally agreed that category four and five presentations at emergency departments could be addressed at GP clinics rather than in hospitals.

Suggested Improvements

- Reference was made to a previous PHN Ambulance Avoidance Program. It was explained that such a program involved a GP finding out what the patient needs and communicating with the ambulance and emergency department prior to the patient presenting at the emergency department. In this way the emergency department would also be informed of incoming patients and their needs (consultations with forum participants).
- It was suggested that pharmacies have a triage role, although this would require extensive training particularly in relation to responding to people with mental health or AOD issues (consultations with forum participants).
- Provide hospital liaison workers to communicate with patients waiting in emergency departments to provide information about other afterhours healthcare options in order to divert patients who could clearly have their needs met elsewhere (consultations with forum participants).
- Explore option of establishing liaison workers/specialist aged care nurse practitioners in EDs to facilitate more appropriate patient care in and out of hospital, especially for vulnerable groups: homeless; AOD; CALD. Emphasise the follow up of discharge plans to ensure patients actually take up the onward referrals – for example, could trial the appointment of a specific worker to follow up on all discharge plans from ED (consultations with St Vincent's GP Liaison – very strong on increased use of nurse practitioners; Eastern Health RIR; St Vincent's RIR; EMPHN Mental Health Team)
- Every hospital have a partnership with a large clinic that it can refer category four and five patients to. This could involve the EMPHN supporting the necessary infrastructure and moving GPs to areas with highest needs. If a formal partnership is established then issues of hospital liability can be addressed. Large clinics will be responsive to this approach if there is sufficient throughput of patients to make it financially viable with bulkbilling. An additional model involves formal agreements for Deputising

Services doctors to have access to a room to treat category four and five patients as part of their rounds (consultations with MDS Service and forum participants)

- Examine how many categories 4 & 5 ED patients actually ended up in hospital, i.e. we cannot always assume such people are inappropriate to come to hospital (consultations with St Vincent's GP Liaison).

7. Towards Solutions: Discussion and Analysis

Analysis of data and literature from national and overseas sources, including the work done to date by the EMPHN, and the most recent consultations, have identified that a number of the 2015 EMPHN priorities remain relevant in 2017 and suggest that there is significant agreement about the considerable challenges in delivering after-hours healthcare across the EMPHN catchment. Moreover, there are indications that in some cases, despite considerable efforts to provide high quality accessible after-hours healthcare, the provision of after-hours healthcare services remains problematic. The data further points to the importance of considering after-hours healthcare program design in the context of the social model of health, with consideration of the social determinants of health specific to the EMPHN catchment. The social determinants of health (SDH) are understood as the social, environmental, political and cultural conditions into which people are born, grow, live work and age, and factors that enable or impede the health and wellbeing of individuals and communities (World Health Organisation Commission on Social Determinants of Health, 2008).

This approach offers the potential to disrupt current thinking about how to tackle the after-hours healthcare challenges and provides an opportunity to re-consider how to address these challenges in a proactive and intersectional manner. As a result we have framed the proposed priorities using the social model of health framework and at the same time acknowledging the interaction with clinical factors. We consider that this may offer a pathway that could make a difference to the way the community and providers approach after-hours healthcare.

Further, from the project findings it may be reasonable to conclude that a strategic approach is important whereby key strategic priorities can direct cross-sectoral and catchment-wide programs to achieve systemic workforce and service delivery outcomes. In light of this approach, the following recommendations are intended as large pieces of work that can make a difference in after-hours healthcare services across the EMPHN catchment, rather than focusing on recommendations to address specific and recurring issues reflected in the consultation findings reported earlier.

Importantly, we recommend the development of outcomes measurement evaluation frameworks underpinning all of the following proposed priorities. This is essential for determining the impacts of after-hours healthcare services and service utilisation on health and wellbeing.

Current Priorities	Proposed Priorities
1. Limited access to GPs and other primary health care services in the after-hours period **2.** Limited RACF access to GPs and other primary health care services in the after-hours period **3.** Increase quality and capacity of after-hours primary health care services **4.** Increased community awareness of after hours services and options **5.** Culturally safe and accessible primary health care services for Aboriginal and Torres Strait Islander, and CALD and Refugee people **6.** Increased access to mental health services in the after hours period (*Activity Workplan Template* EMPHN, 2016).	**1. Change community attitudes and behaviours in the way people understand and use after-hours healthcare services. This includes awareness raising and educational co-designed and evaluated campaigns and interventions.** **2. Fund and facilitate the co-design of innovative after-hours healthcare programs that are underpinned by cross-sectoral and inter-professional arrangements.** **3. Develop internally integrated and cross-catchment after-hours healthcare programs.** **4. Have a resident-centred systems approach to after-hours healthcare in RACFs.** **5. Use a cross-sectoral approach to engage healthcare professionals in workforce development on appropriate after-hours healthcare responses.**

The issues, EMPHN responses to the issues and recommendations included in each of the following tables are based on previous work and consultations undertaken by the EMPHN, demographic data provided in this report; and review of literature including other PHN projects, discussed earlier in this report.

7.1 Priority 1: Change community attitudes and behaviours in the way people understand and use after-hours healthcare services. This includes awareness raising and educational co-designed and evaluated campaigns and interventions.

Issues	Responses to issue by EMPHN	Recommendations
Previous work undertaken by the EMPHN, research by other organisations as well as the findings of the current project indicate that many people in the community: • Don't know about the range of after-hours healthcare services available and how and when to access them, including people with limited English or knowledge of the Australian healthcare system. • Present at hospital emergency departments after hours for conditions that could be treated by a GP for routine care. • Cannot accurately assess (except in emergencies) when they should take their children to hospital after hours, instead of waiting to see their GP during business hours. • Believe that they are more likely to receive appropriate healthcare afterhours at a hospital than a GP clinic especially, e.g. if they are likely to need pathology, radiology or other specialist services, i.e. a one-stop-shop • Do not understand how they may take action, such as timely GP appointments, that could reduce the likelihood of them requiring after-	Working with a number of organisations and community groups, including Hospital Networks and CALD organisations, have identified a lack of community awareness around accessing health care in the after- hours . EMPHN has developed a number of resources including brochures and fridge magnets for the community about accessing Health care After Hours as part of an overarching community awareness campaign. Evaluating these programs is extremely difficult and further research is required to ensure effective evaluation frameworks are embedded within any community awareness projects.	**1.** EMPHN identify a range of community-based strategies to investigate and better understand the attitudes that drive community's behavioural choices in seeking after-hours healthcare. This should be informed by demographic and service utilisation data and outcomes of similar programs in other catchments and more broadly with tailored strategies for specific population cohorts such as CALD, Indigenous, disability, mental health, AOD, young people etc. The purpose of this work is to find out what would help to change after-hours healthcare seeking behaviours and attitudes. **2.** EPHN liaise with appropriate organisations to access expertise in designing effective, evidence-based health promotion campaigns to increase community awareness. Key considerations should include: • Educating people about how to minimise seeking after-hours healthcare through better management of healthcare requirements during in-hours.

Issues	Responses to issue by EMPHN	Recommendations
hours healthcare intervention. • Do not want to pay a gap fee for after-hours services provided by GPs or other practitioners.		• Investigation of the drivers to decision making in relation to seeking after-hours healthcare; and how they may be addressed. • Investigation of how people assess risk in relation to seeking after-hours routine healthcare and emergency healthcare. • Identification of best practice strategies for educating the community to build people's confidence in decision-making and their agency.

7.2 PRIORITY 2: FUND AND FACILITATE THE CO-DESIGN OF INNOVATIVE AFTER-HOURS HEALTHCARE PROGRAMS THAT ARE UNDERPINNED BY CROSS-SECTORAL AND INTER-PROFESSIONAL ARRANGEMENTS.

Issues	Responses to issue by EMPHN	Recommendations
Research, literature and the findings of this project indicate that after-hours healthcare services may be less effective because: • They do not respond directly to the presenting needs of some people, e.g. people with mental health or AOD issues, people who are homeless, people from CALD backgrounds. • They may not be well integrated and there is not a continuum of care between services provided during business hours and after-hours. • There isn't cross-sectoral collaboration such that the interventions of respective practitioners across sectors inform one another, e.g. GP's collaborating with ACFSs, mental health professionals, disability workers, CALD workers etc.	EMPHN has worked collaboratively with a number of external organisations to implement effective after hours activities. Future work commissioned in this area will need to ensure collaboration both internally and externally as many issues identified cross a number of program areas and affect different population groups within the community • Any services procured should be underpinned by a comprehensive commissioning process including co-design of solutions.	**1.** EMPHN facilitate a suite of activities, e.g. workshops, networks, forums, to establish systems for cross-sectoral program design of after-hours healthcare interventions. This approach should consider incentivisation of practitioners and sectors to enable their ongoing participation. Initial focus on under-serviced geographic areas and population cohorts, e.g. people with mental health issues and people living in outer suburbs, is recommended. **2.** Utilise the information provided in section 5 of this report to generate program ideas, e.g. • Central Queensland PHN Spot On program. • Home-based programs that may include a nurse-led program • Telehealth options, including a cost-benefit analysis given current availability and funding constraints.

7.3 PRIORITY 3: DEVELOP INTERNALLY INTEGRATED AND CROSS-CATCHMENT AFTER-HOURS HEALTHCARE PROGRAMS

Issues	Responses to issue by EMPHN	Recommendations
Data and research suggests that systemic consolidated approaches are required to address the identified after-hours healthcare issues across the EMPHN catchment. Consultations indicate that the integration of EMPHN after-hours programs within in-hours programs could produce more seamless approaches for addressing after-hours healthcare issues, and generate new opportunities, e.g. the mental health program including after-hours healthcare, the GP engagement team working with after-hours GPs etc.	EMPHN has identified that some areas within the organisation have operated strictly within their program areas which does inhibit cross polinization of project ideas and sharing of procurement information.	**1.** EMPHN commission projects that demonstrate a systemic approach to the provision of after-hours healthcare. **2.** EMPHN review and develop internal structures and funding arrangements to facilitate collaboration across EMPHN programs in order to better address systemic after-hours healthcare issues, e.g. AOD, mental health and GP programs working jointly to design after-hours healthcare approaches.

7.4 PRIORITY 4: HAVE A RESIDENT-CENTRED SYSTEMS APPROACH TO AFTER-HOURS HEALTHCARE IN RACFS

Issues	Responses to issue by EMPHN	Recommendations
Previous and current research of RACFs suggests that: • Some staff are not appropriately trained to make confident decisions about residents after-hours healthcare interventions. • Cost issues can influence the employment of staff with skills for addressing after-hours healthcare needs. • Advanced Care plans are not used consistently, at all, or appropriately to make decisions with residents and their families about after-hours healthcare requirements. • Policies and procedures by individual RACFs may prevent opportunities to examine a range of after-hours healthcare responses, e.g. policies that encourage staff to call an ambulance first. **3.** Relationships between RACFs and GPs are generally based on a reactive regime rather than a proactive one, e.g. it is not commonplace to have an agreed regime about medication management between the RACF, GPs and Pharmacists to reduce long waits for prescriptions for medications after-hours and encourage in-hours prescribing.	Work with the Local Hospital Networks including Eastern, Northern, Austin and St Vincents have identified issues around admission, discharge and Advance Care Planning Processes. EMPHN has initiated the Residential In Reach Education for RACF Staff and MDS - Establishment of a collaboration between three Residential In Reach Services operates within the EMPHN catchment, namely Eastern Health, Austin Health and Northern Health to implement a coordinated educational program. Eastern Health is the lead organisation and has coordinated activities by appointing a Project Officer. The collaboration provide training to RACF staff, GPs and locum services on early recognition, escalation and assessment of a deteriorating resident and an awareness of the options for facility-based acute care, which may reduce the need for transfer to hospital .	**1.** EMPHN pilot a project to expand the quantity and quality of Advanced Care Plans to facilitate healthy discussions between families and practitioners about appropriate responses to (deteriorating) health of family members, and then between family members and the RACF. **2.** EMPHN design and fund a demonstration project to build person-centred care in RACFs involving residents, families, RACF staff and practitioners providing healthcare.

7.5 Priority 5: Use a Cross-Sectoral Approach To Engage Healthcare Professionals In Workforce Development On Appropriate After-Hours Healthcare Responses

Issues	Responses to issue by EMPHN	Recommendations
Workforce issues impacting the delivery of after-hours healthcare have been reiterated. Key issues include: • Lack of GP workforce limiting the ability to provide consistent, routine high level after hours care. • Limited staff in RACFs with appropriate skills in after-hours healthcare. • Limited understandings and/or skills by GPs responding specific population groups, e.g. people with mental health issues • Limited understandings by GPs about cross-sectoral service systems, e.g. mental health and AOD services.	Procurement of services by EMPHN, particularly in the Aged Care Sector have identifed workforce issues to be an inhibiting factor in delivering services (recent contract with an After Hours GP Service Provider) RACFs	**1.** EMPHN facilitate opportunities for cross-sectoral and ongoing workforce development including but not limited to areas such as: • Systems for sharing patient information, e.g. e health technology • Cross-sectoral continuity of care where patients are involved with multiple agencies • Development and application of tools and resources, including resources for specific population groups, e.g. health literacy for parents with children.

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9. APPENDICES

9.1 APPENDIX 1: CONSULTATION PROTOCOL

Consultations with key informants were conducted individually and in two group forums. A number of individuals were unable to be consulted within the project timeframe. The following table provides information on who was consulted and the method of consultation.

9.1.1 INDIVIDUAL CONSULTATIONS

Organisation	Name	Position	Tel	Face to face
DoctorDoctor	Nic Richardson	General Manager		
	Meredith Deiure	Business Development Manager		
	Liz Morgan	Liaison Officer		
HomeDoctor	Andrerw McInerney	General Manager		
EMPHN Clinical Council	Andrew Robinson	Pharmacist - Retail Pharmacist and on EMPHN Clinical Council		
Ambulance Victoria	Danny McGennisken	A/Operational Communications Liaison (referred by Pharmacy Guild)		
Nillumbik and Research Medical Centre	Kirstin Lyons	Practice Manager		
	Felicity Emery	Clinical Manager		
Mooroolbark Superclinic (corporate)	Rizwan Lotia	GP		
	Amila Munasinge	GP		
St. Vincents Health	David Isaacs	GP Liaison Coordinator		
	Una McKeever	Complex Care Services Manager		
	Darren Gaut	Team Leader, RIR		
Northern Health	Clare Poker	Associate Program Director; Health Independence Program and Hospital in the Home		
	Sharyn Beard	Partnerships Manager		
	Peter Jordan	Emergency Department Director		
	Sandra Brown	Medical Director Sub Acute Medicare		
Eastern Health	Julie Evans	Manager Chronic Care and Well Being		
Austin Health	Clynt Bernhardt	Nurse Unit Manager, Hospital in the Home and Residential Outreach Services		
	Karen Dettering	Manager, Advanced Care Planning		
Monash Health	Helen Stubbs	Operations manager		
EMPHN	Dianne Hayes	GP Engagement Coordinator		
	Steph Lenko	GP Engagement Team - General Practice Engagement Officer (North)		
	Sue Keane	GP Engagement Team - General Practice Engagement Officer (Outer East)		
	Denise Jones	GP Engagement Team - General		

Organisation	Name	Position	Tel	Face to face
		Practice Engagement Officer (East)		
	Mandy Taylor	System Reform Lead, Mental Health and AOD		
	Anne Lyon	Executive Director, Primary Care Services		
	Maria Yap	Mental health Nursing Program and AOD Program		
	Rachel Pritchard	Intake Manager, Mental Health Services		
	David Johnstone	Epidemiology Officer		

9.1.2 Group Consultations

EMPHN Community Advisory Group -12 participants

9.1.3 Forums

Session 1

	Prefix	First Name	Surname	Job Title	Company
1	Mr	Nicolas	Richardson	General Manager	DoctorDoctor
2	Ms	Meredith	DE IURE	Business Development Manager	DoctorDoctor
3	Mr	Andrew	McInerney	General Manager	National Home Doctor Service
4	Ms	Una	McKeever	HIP Manager	SVHM
5	Ms	Shumei	Liu	pharmacist intern	Advantage pharmacy group
6	Ms	Sophie	Lloyd	Senior Program Adviser	Department of Health & Human Services
7	Ms	Laura	Colliver	GP Services Manager	Nexus Primary Health
8	Mrs	Brianna	Harris	GP Services Team Coordinator	Nexus Primary Health
9	Ms.	Liz	Morgan	Liaison Officer	DoctorDoctor
10	Dr.	Zizi	Shenouda	GP	Kingsville's Health

Session 2

		First Name	Surname	Job Title	Company
1	Ms	Sophy	Athan	Community Advisory Committee	Eastern Melbourne PHN
2	Ms	Kylie	Payne	General Manager	Burwood HealthCare
3	Mr	Anthony	Lu	Pharmacist	Vermont Pharmacy
4	Ms	Caroline	Long	Pharmacist	Balwyn Day and Night Pharmacy
5	Mr	Peter	Valastro	Pharmacist Proprietor	Care More Pharmacy Pty Ltd
6	Mr	Theng	Fong	Pharmacist	North Ringwood family pharmacy
7	Mr	Douglas	Lau	Pharmacy area Manager	Chemist Warehouse Knoxfield

All those approached to be consulted received the following background paper prior to the consultation.

AFTER HOURS PRIMARY HEALTH CARE DIAGNOSTICS AND PRIORITISATION PROJECT

CONSULTATION DISCUSSION PAPER

April-May 2017

Overview

The Eastern Melbourne Primary Health Network (EMPHN) has contracted consultants Russell Jaffe, Liz Dimitriadis and Anne Smyth (Jaffe Consulting Pty Ltd) to undertake the 'Diagnostics and Prioritisation' Project for the Network, aiming to establish the key priorities for service delivery for the coming years.

In 2015 EMPHN completed a preliminary Comprehensive Needs Assessment (CNA) of its catchment's primary health care needs. This included a review of the CNAs prepared by the three Medicare Locals on whose catchments EMPHN is based. This work informed the development of a plan to address after hours primary care needs however a deeper understanding of issues and gaps which have been analysed systematically is now required.

Project Objectives

EMPHN have identified four key objectives for this Project:

1. *Conduct a rapid review of after-hours primary health care access issues using a systematic approach and sound sampling methodology to obtain a view of the after-hours catchment needs and subsequently identify the top five (5) AH Primary Health Care issues across the EMPHN catchment.*
2. *Determine the impact that regional characteristics may have on the after-hours needs of the community including: Identifying services available, utilisation of services, access inhibitors and health literacy concerns.*
3. *Identify factors impacting utilisation of services including workforce capacity of GP medical services, medical deputising services (MDS) and Emergency Departments' (ED) capacity to service regional after-hours needs.*
4. *Ensure that the information gathered is from a representative sample of stakeholders including general practices, pharmacies, residential aged care facilities, MDS, hospital networks and groups for whom access to primary care is more likely to be an issue.*

Current Priorities

EMPHN's current set of service delivery priorities were established in 2015 and now require revisiting and deeper analysis. These priorities are as follows:

1. **After Hours Access:** Limited access to GPs and other primary health care services in the after-hours period.
2. **GP Access for Aged Care:** Limited residential aged care facilities access to GPs and other primary health care services in the after-hours period.
3. **After Hours Services:** Increase quality and capacity of after-hours primary health care services.
4. **Community Awareness:** Increased community awareness of after-hours services and options.
5. **Culturally Safe Services:** Culturally safe and accessible primary health care services for ATSI, CALD and refugee people.
6. **Mental Health Services:** Increased access to mental health services in the after-hours period, particularly in regard to young people

Other Key Issues for Consideration

1. **Innovation**: Different/innovative ways of doing things, e.g. central triage line.
2. **Service Scope**: Identify 'hot spots beyond GP provision including mental health and pharmacy services – needs and provision.

2. **Aged Care**: Should the visiting GP service be expanded? Impact of medication administration when GPs not available.
3. **Emergency Departments**: How to reduce primary care presentations at Hospital Emergency Departments?
4. **Telehealth**: Telehealth as a service option (currently need to be at least 15km from a health service to qualify for a telehealth consultation.
5. **Rural Services**: GP access for semi-rural areas, e.g. Hills/Upper Yarra.
6. **Vulnerable Groups**: Services for vulnerable groups – CALD, ATSI, homeless.
7. **Overprescribing**: Overprescribing; poly-pharmacy/too much medication.
8. **Admissions**: How are decisions made about after hours admissions?
9. **AOD patients**: What is the best way to provide medical care after hours?
10. **Geographic Reach**: Where are the locations where GPs are most required (hotspots)?

The data will be used to understand the dynamics of the needs, issues and gaps identified across the catchment, assess their strength and proportionality and provide a credible basis for EMPHN to determine priorities for action going forward.

Consultation Schedule

Consultations will be conducted during April and May 2017 using a variety of methods including:

- Face to face interviews.
- Focus groups.
- Forums.
- Group discussions.
- Surveys (if appropriate).

Consultations will be conducted with:

1. Consumer groups – Council Advisory Groups.
2. Direct Service Providers and Services affected by the way after hours primary health services are provided:
    - GPs.
    - Community Health Services.
    - Pharmacists.
    - Hospital Networks.
    - Medical Deputising Services.
    - Residential Aged Care Facilities.
    - Local Councils.

- Specialist Services, e.g. Headspace, Ambulance Vic.
- Primary Care Partnerships.
- Local Health Networks.

3. EMPHN departments/project areas.

Consultation Questions

Consumer Groups – Council Advisory Groups

It is anticipated that members of Council Advisory Groups will consult their constituents and provide feedback on the following guiding questions. For reference, after hours refers to after 6:00pm weekdays, after 12.00pm on Saturdays and all day Sundays.

1. How are you and your family currently accessing general practice type services after-hours in your suburb? (Important to identify geographic location).
2. If you have to travel, how long does it take you?
3. Do you know of a pharmacy in your area you can access after hours?
4. What kind of services do you need after hours? Is this mostly appointments for your usual care because you are busy during the week?
5. What do you know about primary health services available after hours and how to access them? Where do you get your information?
6. Do you know of community members that you think would not have access to this information?
7. How easy is it to obtain after hours primary health care? Are there any difficulties? Some stories of peoples' experiences would be useful.
8. What would make it easier for people to obtain timely and appropriate after hours primary health care?
9. In your opinion, what should be invested in over the next 2-3 years to improve after hours care?
10. What medical or mental health services do you know of that are very busy after hours and difficult to get into? Are there certain days or times when this is worse?
11. The section 'other key issues' above has highlighted some salient factors. Do any of these stand out for you as needing priority or particular attention?

Direct Service Providers

1. What are the most common health conditions for which people need after hours primary health care?
2. What primary health services are provided after hours and how are the services delivered?
3. How are primary health services currently deputized? How effective is this? What changes are needed and why?

4. Are there critical geographical areas where populations are unable to adequately access GPs and other after hours services?
5. Are there any primary health service gaps, i.e. services that should be delivered after hours, e.g. mental health, AOD?
6. What are the key factors that enable the delivery of services after hours and the factors that get in the way?
7. What improvements could be made to the way primary health services are delivered after hours at present to minimize presentations at hospital emergency departments, e.g. service location, cost, scope of intervention?
8. What significant impact projects should EMPHN therefore be undertaking or funding over the next 2-3 years to improve after hours care?
9. The section 'other key issues' above has highlighted some salient factors. Do any of these stand out for you as needing priority or particular attention?

Services affected by the way after hours medical services are provided

1. What are the most common health conditions for which people need after hours primary health care?
2. What number/percentage of presentations could have been serviced through an after-hours primary health service? What type of health conditions are these?
3. What are the key issues that prevent people from accessing after-hours primary health services?
4. What is the impact of this unnecessary access?
5. What are key issues in GPs being able to provide comprehensive and timely primary health services after hours?
6. What could be potential improvements to providing after-hours primary health care, e.g. geographic reach, health literacy, scope of medical intervention (e.g. mental health, AOD services)?
7. What significant impact projects should EMPHN therefore be undertaking or funding over the next 2-3 years to improve after hours care?
8. The section 'other key issues' above has highlighted some salient factors. Do any of these stand out for you as needing priority or particular attention?

EMPHN Departments/Project Areas

1. What are the key patterns that must be considered in planning for after hours primary health services?
2. What are key issues in:
    a. Changing people's behaviour and understanding to accessing after-hours services?

b. Changing the way after hours primary health services are provided and deputized in order to reduce ambulance callouts and emergency department presentations?

3. What are the key considerations for maximizing after hours services for non-urgent care in order to reduce Emergency Department presentations, e.g. service system, resources, community characteristics?
4. What are important strategies that could initiate positive changes to the utilization of after hours primary health services by the community?
5. What significant impact projects should EMPHN therefore be undertaking or funding over the next 2-3 years?
6. The section 'other key issues' above has highlighted some salient factors. Do any of these stand out for you as needing priority or particular attention?