

2 October 2006



Review of

**ACUTE DEMAND AND AFTER HOURS
in Primary Care**

Planning and Funding

October 2006

1.0 EXECUTIVE SUMMARY

The Canterbury District Health Board (the DHB) began a review of Acute Demand and After Hours services in March 2006. This review was driven by:

- An identified increase in people presenting at the Christchurch Hospital Emergency Department (ED), and the understanding that a number of these people could be treated elsewhere; and
- The DHB was given a period of 12 months, until February 2007 to develop a direction for after hours services, as per the outcomes of the “Towards Accessible Effective and Resilient After Hours Primary Health Care Services” report.

The DHB contracts with community providers to provide community based acute services. Initially these agreements had an impact on the level of presentations at the Christchurch Hospital Emergency Department (ED), however over the past two years particularly there has been a continued increase in these numbers.

The aim of this review is to provide a framework for the future management of services in the community. The project objectives were to consider strategic approaches to service delivery in order to alleviate the continuing pressure on emergency and acute services provided by ED, General Practice and Community and District Nursing Services in Canterbury.

During the review all key services in the community funded by the DHB and other health providers in Canterbury were reviewed. Additionally, workshops and discussions were held with key stakeholders and a literature review undertaken. This process identified a number of gaps in the provision of community acute services, and some duplication in service coverage. The process found many services and service providers working in isolation, with some providers expressing difficulty in establishing linkages that could provide support or sharing of information and expertise with each other. It also identified significant fragmentation of information systems and between the various service providers.

The process also identified issues with the availability and analysis of data particularly regarding the patient populations attending ED. Additionally there is no current mechanism in place that enables existing ED data to be matched with primary care datasets. These differences limited the scope of recommendations that could be made within the initial stages of this review. Subsequent to the review the DHB has further investigated the ED data available. The findings support and enhance the recommendations made in this paper. However there is scope for further analysis of the data and the potential for further recommendations in the future.

The DHB has taken a strategic framework approach to this review; however, it has also identified a number of services, which if put in place would have a major impact on the management of acute services in the community. The DHB is aware of the need to consider any recommendations as a continuance of existing service coverage. Therefore the DHB will implement the following acute demand service improvement initiatives:

1. A management group, within the Improving the Patient Journey Project to encourage a collaborative and coordinated approach across all stakeholders, and giving consideration to the priorities and themes identified.
2. That the DHB investigate further the following services and projects
 - A Primary Health Care Public Education Promotion Campaign
 - A Specialist advice service to General Practitioners (GPs) from the Acute Medical Admission Unit (AMAU)

- A Nurse-led after hours telephone advice service for the general public
- Packages of Care for All – which may include:
 - an acute nursing and home support team; and
 - a community observation facility
 - a variety of specific services such as deep vein thrombosis treatment
- Service Coordination function for any new services
- A rapid response team operating from the St John Ambulance Service
- Improving access to rapid diagnostic services in primary care
- Aged residential care services education programme
- General Practitioner based in the Emergency Department

2.0 BACKGROUND: Our Challenges and the Way Forward

The DHB is responsible for the funding and provision of public health and disability services in the Canterbury region. The DHB covers a population of more than 470,000. It is the second largest DHB by population and the largest by geographical area.

In developing the District Strategic Plan (and alongside its identified Strategic Priorities) the Canterbury DHB identified five Core Directions which will be essential to achieving the changes and improvements needed to make to meet our challenges in the next 5-10 years. Those Core Directions are to:

1. Improve the health and wellbeing of our community;
2. Find better ways of working;
3. Work together;
4. Develop our health care workforce; and
5. Be a leader in health.

Canterbury DHB has a number of unique challenges, which include an ageing population, inequalities in health status and access to service, funding uncertainties and challenges in promoting integrated care, raising health awareness and further developing primary care. Canterbury DHB has identified meeting the increased demand for services as one of the major challenges over the next 5 to 10 years. In looking at this challenge the DHB will be actioning a number of initiatives and projects over the next five years under its Core Directions – primarily under the Core Direction “Work Together”. These include:

- Collaborating with the wider health sector to implement continuums of care; focusing particularly around acute demand, chronic care and high and complex needs including the links between primary, secondary and tertiary care;
- Continuing to build strong and respectful relationships with the community and work with providers to ensure services are complementary and enhance the continuum of care;
- Progressing current integration pilots and programmes to incorporate PHOs as key partners in the management of demand on hospital and specialist services; and
- Enhancing referral guidelines and education for both primary and secondary providers to improve appropriate utilisation of speciality and emergency services.

However, the key and overarching challenge for Canterbury DHB is working within funding constraints as a result of population-based funding. There is an ongoing process to identify efficiency gains to ensure value for money and, where appropriate, implement initiatives to manage and/or reduce costs. In developing strategies or undertaking future reviews the DHB will continue to identify areas where integration, best practice models, efficiencies, re-configuration or earlier intervention can produce better value and outcomes from available funding. Canterbury DHB is committed to ensuring that

opportunities of this nature continue to be identified and acted upon to realise health gains for our community.

Following the directions in the DHB Strategic Plan and the Core Directions document, a review of acute demand and after hours services was initiated. This review was driven by:

- An increase in people presenting at the ED, and the understanding that a number of those presenting could be treated elsewhere
- Following the “Towards Accessible Effective and Resilient After Hours Primary Health Care Services” report the DHB has until February 2007 to develop a direction for after-hours services in Canterbury
- The pending expiry of a number of community acute demand service agreements

The initial stages of this review were to:

- Review the current status of the DHB contracts for acute demand and after-hour services in the community, discussions with providers’ clinicians and hospital staff;
- Develop a framework and future direction of acute demand and after hours services in Canterbury.

3.0 INTRODUCTION

The review of acute demand management and after hours services in Canterbury aims to provide a framework for the future management of services in the community. The project objectives are to consider strategic approaches to service delivery in order to alleviate the continuing pressure on emergency and acute services provided by the ED, General Practice and Community and District services in Canterbury. These approaches must include service delivery options that maximise the benefits from the funding available.

The term ‘Acute Demand Management’ describes a cluster of processes that are put in place across a health service to reduce such demand on acute services. It generally includes two steps:

1. The identification of specific patients or patient populations who tend to impact heavily (and disproportionately) on acute services – this normally includes those with chronic diseases and those in socio-economically deprived groups;
2. The coordination of an appropriate level/frequency of care in the primary care/community/social services setting for these patients, based on best-practice guidelines, so that their attendances at hospital are reduced or eliminated, reducing cost and resource issues for acute care (and improving health outcomes and quality of life for patients (Pencheon).

Underlying assumptions inherent in the review include:

- Approaches must work towards goals outlined within the DHB Core Directions Document (2005 – 2006), including the goal to eliminate waste and any duplication from our services and working collaboratively with health care providers so that the best use is made of combined resources
- There is potential to better utilise existing resources by redesigning existing services and developing new methods of service delivery
- The management of acute demand services should be looked at as a whole, including general practice after-hours cover
- An inclusive approach to acute demand service planning would achieve a broader service infrastructure to meet identified needs
- There are national and international models regarding improving patients’ primary care contact, and therefore management, which could be applied to the Canterbury situation.

4.0 CURRENT SERVICES

Before we can consider how to improve after hours cover and acute care in the community we need to evaluate the current services provided within Canterbury.

4.1 After Hours Cover

All Primary Health Organisations (PHOs) in Canterbury are contracted to the DHB to provide services in accordance with the National PHO agreement. This agreement requires that PHOs provide first level services 24 hours a day, 7 days a week. This requirement intends that PHOs ensure General Practice cover outside normal working hours, or "after hours."

PHOs nationally have indicated that while this is within their agreement, they believe they are not funded adequately to provide this level of service coverage. However, District Health Boards (DHBs) and the Ministry of Health (MoH) have stated that funding for after hours cover is included as part of the capitation based funding that PHOs receive and general practices are entitled to charge a premium co-payment for services provided outside normal hours.

In 2005 a national working party was formed to look at after hours issues. This working party developed a report "Towards Accessible Effective and Resilient After Hours Primary Health Care Services." The outcome of this report was that individual DHBs are required to develop an after hours direction paper.

Within Canterbury, all PHOs provide a variety of after hours services. These include the only private 24 hours general practice surgery in New Zealand (owned by Pegasus Health) and a variety of emergency clinics with extended hours. Within rural Canterbury, PHOs are funded to ensure Reasonable Rosters for their General Practitioners. There has been an investment of over \$1M per annum of rural premium funding in Canterbury to support rural practices, and acknowledge the impact of providing after hours cover in rural areas.

One Canterbury PHO currently allocates up to 13% of its capitation funding to cover after-hours services. However, patients are still charged around \$90 for a standard adult consultation after hours. Other General Practitioners (GPs) in Canterbury charge up to \$250 for a home visit after hours.

There is however some discontent within General Practitioners regarding the provision of after hours services. In an attempt to relieve the pressures on General Practice, one rural Canterbury PHO has implemented a nurse lead phone triage after hours service. This has proven to be a successful pilot.

4.2 Acute Demand Services

The first stage of this review was for the DHB to evaluate the current level of services contracted in the area of community acute demand. The review identified a variety of providers in Canterbury who provide community acute demand services or have the ability to provide these services.

The main service provider for managing acute services in the community is General Practice. In Canterbury there are over a million consultations within General Practice per year, with the majority of these managing the needs of the community effectively within their current practices.

Historically, to support the role of General Practice the DHB has contracted with Pegasus Health to provide a variety of community acute demand services including acute nursing teams, packages of care, urgent diagnosis and an observation service.

The DHB also contracts with community nursing services and home based support providers to deliver services to people within their own homes, or to assist in facilitating early hospital discharge. The agreements with these providers require that they provide a 24 hour service and respond acutely if required. A number of General Practices, utilise these services, particularly in rural Canterbury,

5.0 KEY ISSUES

5.1 Gaps in Current Service Delivery

The initial scoping of services identified a number of gaps in the provision of after hours and acute community care in Canterbury. These include the following:

- After hours cover is sporadic across Canterbury with no single affordable alternative to the ED within existing services.
- Coordination of community based care and linkages between providers (eg between district nursing and General Practice) is limited.
- Continuity of care: there are gaps in after hours post discharge nursing care and where wards are closed or patients discharged without notice during weekends
- There are no services for high needs patients who are not attending general practices but presenting at the ED eg a cohort of Maori men.
- There are potential gaps in service delivery in single provider services (eg IV Therapy) or where eligibility criteria rather than assessed need determines access to services.
- Telephone advice services: rural providers consider that Healthline does not serve the needs of the rural community particularly well as it lacks linkage back with general practice.
- The interface with secondary services, particularly where patients are not referred back to their GPs.
- Specific services such as deep vein treatment, IV therapy, falls prevention programmes, family planning, mental health, "Dinner Bed and Breakfast" and the services to improve access programmes are not readily available to all patients in Canterbury, being Christchurch focused.

5.2 Duplications in current service delivery

A number of service duplications occur including:

- Multiple assessments and care plans particularly where people are accessing more than one service.
- Observation services: provided by Pegasus, other Independent Practitioner Associations (IPAs) and the ED.
- The Pegasus Acute Care Team provides home support and follow up visits which are also contracted to Community Care and home based support providers.
- Infrastructure costs, administration, vehicles, products and training being incurred by multiple providers supplying the same service in the same areas.
- Overlapping between services provided by the Central Coordination Centre and the Pegasus Acute Care Team eg a patient receiving district nursing services for wound care and cardio-respiratory outreach to manage oxygen.
- Information is duplicated due to the lack of a standardised electronic patient information system for Canterbury patients.

5.3 Fragmentation in current service delivery

A number of service fragmentations were identified including:

- Linkages between PHOs and other provider services are limited and could be improved.
- The opportunity to share patient information is frequently missed. All agree there should be some centralised coordinated means of sharing basic patient information.
- Some providers are not always aware of particular services or programmes eg catheterisation, hence the impact on patient care.
- Providers working in isolation (eg regarding older person's health and facilitated early discharge of elderly patients).
- There is little coordination between community nursing services (eg public health, well child health practice, specialist and district nursing services).
- Individual providers making individual arrangements for workforce development.
- The current Acute Demand Steering Group is not representative of all community provider groups. The focus of this group is mainly on the current contracted initiatives.
- Geographical isolation impacts on opportunities for rural nurses to develop and enhance nursing skills.
- Lack of collaboration between services impacts on a number of areas. Services overlap or are duplicated, providers miss the opportunity to build on skills, costs (cars, phones, coordinating and equipment) are duplicated. There is little or no understanding of each other's roles.
- Lack of 7day a week Secondary Care Community Services.

5.4 Changes in the Primary Care Environment

In the past three years Canterbury DHB has seen the development and implementation of PHOs. Five PHOs are now operational in Canterbury, covering over 98% of the total population. Formerly, the DHB contracted with IPAs for the provision of primary care services, which are now provided through PHOs. With this change, the focus for the DHB is on equity and ensuring equal access to services irrespective of which PHO a person is enrolled in. Accordingly, equitable access to primary care services provided by the PHOs is at the forefront of the future development and improvement of acute and after hours services.

5.5 Public Information and Education

During the review period it was apparent that the general public may often be confused about when to visit their GP and when to visit the ED. The data shows a decrease in GP referrals to the ED, but a large increase in people self referring. Consideration needs to be given to how the DHB can educate the population as to when to present at the ED and when they should see a GP.

5.6 Service Coordination

The review identified the need for greater coordination within Canterbury for acute demand, in the areas of services provision and in service planning. Currently, there are numerous acute demand projects underway or completed. There are numerous groups or project streams looking at acute demand management both within the DHB and externally. There is also an Acute Demand Steering Group, made up of representation from Secondary Care and Pegasus Health. This group does not currently reflect the changes in the context of primary care service delivery.

5.7 After hours Requirements

As indicated above there are a number of issues impacting on the provision of after- hours services in Canterbury including the following:

- The General Practice position that after hours services are not funded as part of the PHO capitation based funding
- The increased cost for patients in attending after hours services
- Increasing dissatisfaction from General Practitioners in providing after-hours services.
- The high cost of providing after hours cover.

While Canterbury has the only private 24 hour general practice surgery in New Zealand, the cost to patients of attending this has increased over the past few years. This impacts on people's ability to access the service. Consequently, it is likely that people are presenting at the ED after hours rather than the 24 hour general practice surgery.

5.8 Nurse-Led Triage

The MoH contracts for the provision of a nurse-led phone triage system (Healthline). Feedback obtained during the review indicates that while Healthline is effective there are a number of issues and it is not suitable for all situations. The major issue is that the system does not link back to General Practice, and provide General Practice with the patient feedback they require. Therefore, for both consumers and General Practice teams, Healthline has potential for improvement. One rural Canterbury PHO has piloted an alternative telephone nursing triage service that links after hour calls back to general practice. This has had a positive impact on the services within the rural community. The service has reduced the volume of people presenting at ED, relieved pressure on General Practices during the evening, and has also impacted on the level of residential care referrals.

5.9 Data and Information

The lack of quality data available has limited the scope of the recommendations that could be made on completion of the initial review process. While the available data indicates that attendance at ED is the most clinically appropriate option in the majority of cases, there is concern that a significant percentage of patients present with a primary care level of need which could be and ought to be, treated in the community. It is likely that these patients prefer the ED to their own primary health care provider because of a combination of the matters discussed here, rather than any single factor.

The need for quality data to inform effective decision-making was emphasised by key stakeholders attending both review workshops. As mentioned above, some data analysis was carried out subsequent to the review but more needs to be done to corroborate the findings. For instance, in terms of more focussed and accurate data the DHB needs data to review down to specific patient level, which can be cross referenced, with PHO data to track patient behaviour. This would assist the development of specific services to meet unique client needs. Currently, the DHB does not have access to this specific level of data.

5.10 Relationships and Working Together

In general the relationship between primary and secondary services is good. However in discussions with providers from both the primary and secondary services, it was clear that single service delivery in terms of roles, relationships and funding, underpins some of the limitations of primary and secondary care providers to engage fully with each other. In turn, this contributes to the current deficiencies in acute services as discussed in

paragraphs 5.1 to 5.3 above. Rural and smaller urban PHOs in particular report difficulty in establishing relationships with secondary services, and linkages between all of the urban PHOs could be improved.

5.11 Aged Residential Care

On reviewing the data and following discussions with the sector a number of key issues surrounding Aged Residential Care were highlighted.

- Inability to access after hours General Practice services, or cost limitation around these services. It appears that Aged Care facilities may receive advice from General Practice to go to ED, and this is reinforced by not having to cover the cost of an evening call out.
- Lack of seven day cover in specialist services.
- Lack of appropriately skilled staff within some facilities.

These issues impact on patients being transferred to the ED during the end stage of life, with the patients later dying, in the ED.

5.12 Workforce

The primary care workforce faces staffing shortages and struggles to find staff willing to work extended hours. Cumulatively, this and the fact that the cost of primary care is an issue for a proportion of the population, may be contributing to the increased demand the ED is experiencing currently.

6.0 WHAT THE DATA TELLS US

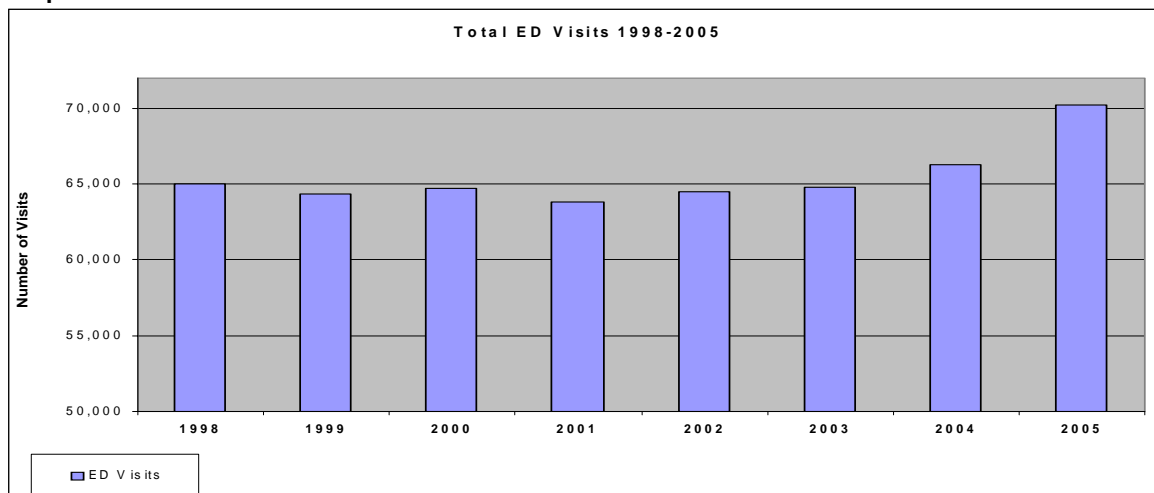
Subsequent to the scoping phase of this review, Planning and Funding carried out a detailed analysis of ED data. This involved reviewing the data over the past 8 years. Summaries of the key findings are as follows:

6.1 Growth

ED visit volumes remained relatively static until 2004, where growth was shown in both 2004 and 2005 to be around 5%. The growth seen in the ED in 2005 compared to 2004 is 3,944 visits. See graph one.

The make up of the extra ED volumes between 2004 and 2005 are mainly people under 30 years of age who make up nearly 64% of the growth observed in that year.

Graph One: Total ED visits 1995 - 2006



Admission rates from the ED have increased from 37% in 1996 to 46% in 2005. Combined with the observed growth in visits per year, especially in 2004 and 2005 this indicates an increase in both acute admissions and care effort required per visit by the ED staff.

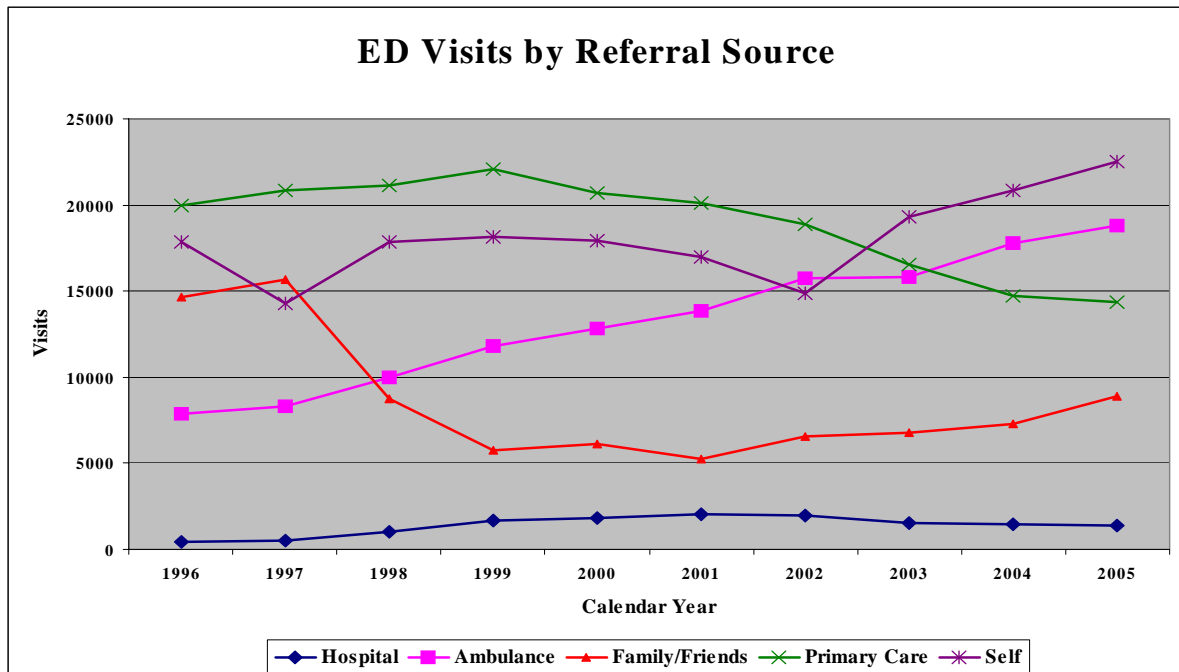
6.2 Referrals

On reviewing overall visits by referral source to the ED, as indicated in graph two, the following observations can be made:

- General practice referrals have declined since 1999.
- Self and family / Friends referrals increased in a step fashion in 2002 / 2003 and have continued to increase since then.
- Ambulance referrals have been increasing since 1996 in a linear fashion and show no signs of moderating.

It is assumed that even though the reduction in GP referrals since 1999 has given the ED relief from higher volume growth, it can no longer compensate for growth from the other referral sources.

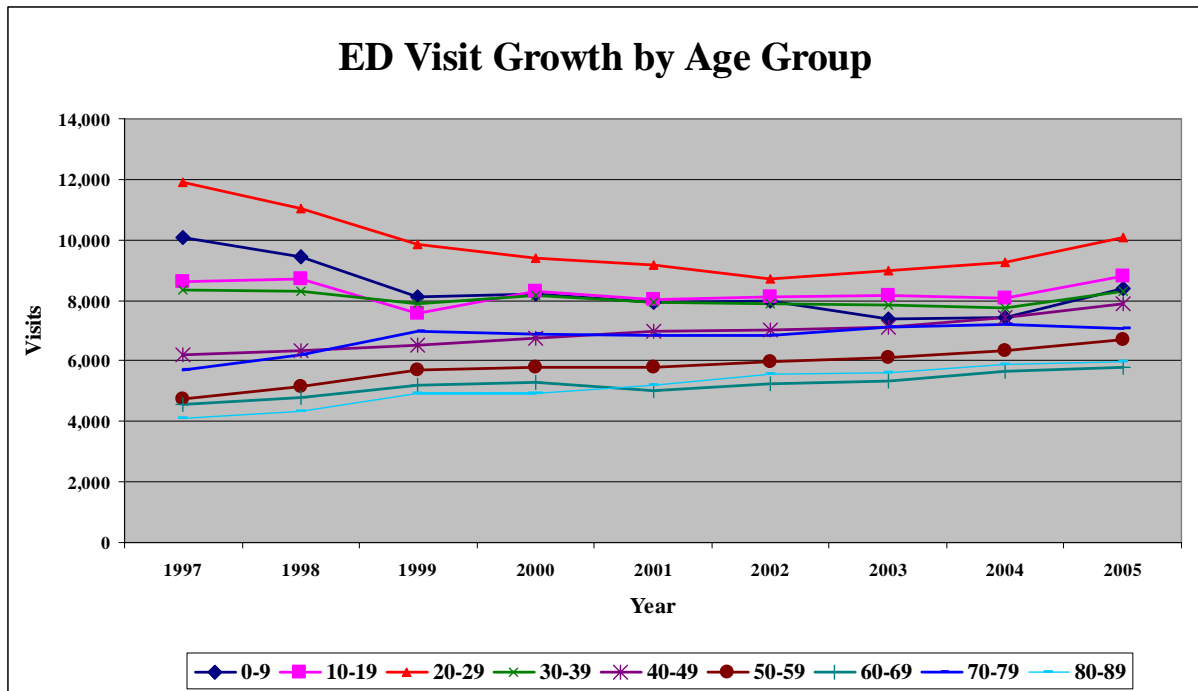
Graph Two: ED visits by referral source



Viewing ED visits by age group, as indicated in graph three, shows the following:

- Young people aged between 10 and 30 years are the biggest users of ED services by volume especially since 2002. The 20-29 year age bracket is experiencing the fastest growth rate of all age groups since then.
- The most sustained growth is coming from the 20-29, 40-49 and 50-59 year age groups. These have been climbing steadily since 2002.
- Overall, the 60+ age groups are also growing but tailed off in the 2005 year.

Graph Three: Growth in ED visits by age group

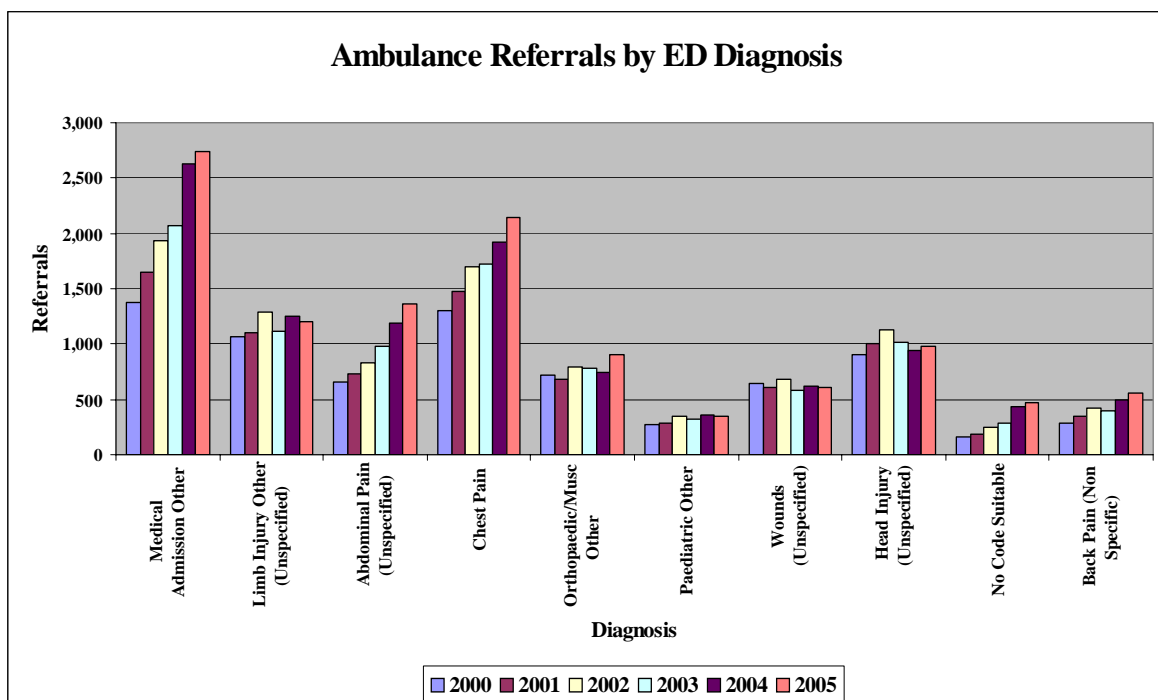


6.3 Ambulance Referrals

Ambulance referrals are increasing steadily. However, not all ambulance referrals require admission. Some patients are treated in the ED and returned home. There is a possibility that paramedic staff could treat more injuries or wounds on site rather than refer and transport into the ED as currently occurs.

The following graph shows the areas of growth by diagnosis for ambulance referrals – Top 10 by volume only. Medical diagnoses are clearly increasing with surgical and injury based diagnoses are growing at a much lower rate.

Graph Four: Ambulance Referrals by ED Diagnosis



When viewing admission rates for medical diagnoses, especially by age group, we see that younger people are being admitted less often. This presents a possible opportunity for managing medical diagnoses in other health settings. Viewing surgical and injury admission rates (“Wounds (Unspecified)” excluded), shows a much higher rate of admission so that no demographic based opportunity presents itself.

6.4 Self and Family Referrals

In April 2003 Self and Family Referrals volumes increased in a step fashion. This indicates something occurred in the community, either policy or service based, which caused visit volumes previously being seen elsewhere to turn up at the ED instead. Understanding what caused this might help return that volume to a more appropriate setting.

6.5 Out Of Hours Family and Friends Referrals

In 2004 and 2005, out of hours family and friend referrals to the ED for the 10-29 age group increased dramatically. One possible cause could be recent change in lifestyle choices made by this group including the use of herbal highs, lower drinking age etc. If this is confirmed, there may be opportunities to treat these young people elsewhere.

7.0 DISCUSSION

7.1 Current pathways to ED

The following diagram is the primary care sectors understanding of the path that people take when presenting at ED. While there are a number of services in place to prevent unnecessary or inappropriate presentations to the ED, there is nonetheless, an increased level of presentations over the past two years.

Diagram 1: Current Points of Entry to the ED

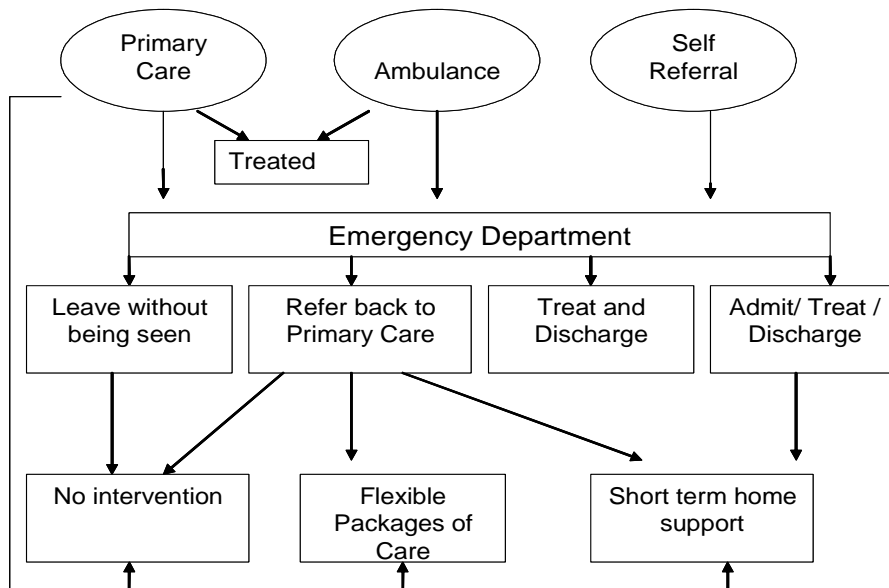


Diagram 1 further indicates a variety of choices regarding access to acute or after hours services, but for some patients eg self referrers, issues such as affordability may limit the choice of service provision leaving the ED as the sole option.

As a major contributing vehicle to ED attendances, the Ambulance service is limited in the point of initial contact it provides currently and where it may direct people when a call out occurs other than to the ED. The Ambulance service has indicated it has the capacity to provide more services, which will impact on after hours and acute presentations.

At the same time, General Practice has signalled interest in obtaining access to acute care services. At present, acute care services are contracted to be provided for the benefit of the whole Canterbury population, however there are barriers to this occurring. The DHB needs to determine how these services can be made available to the whole of the population.

7.2 Current and Future Community Based Services to reduce ED admissions

In the past five years some general practice providers have worked hard to design and implement programmes that make it possible and attractive for General Practitioners to get involved in the management of acute demand services in the community. The DHB acknowledges the work of these IPAs and plans to build on this foundation.

The current acute demand services agreement between the DHB and Pegasus Health has a number of service streams including coordination, packages of care, observation services and Acute Care nursing teams. As identified within the review there is potential for duplication between these and other contracted services in the community. This includes district nursing and home based packages of care. However some concerns have been raised as to whether these providers have the ability to respond acutely. One service provided under the Pegasus Health acute demand services agreement is Dinner Bed and Breakfast. This is where a patient is assessed as needing support for up to a 48-hour period and is placed within a residential facility for this timeframe. Feedback from the review is that this service may result in disincentives for older people, and that older people should be managed within their own home, where appropriate to maintain their independence.

Another service within this agreement is an observation service. This Canterbury wide service purpose is to observe people within General Practice, rather than referring them to the ED. This service had proven to be successful in the past. In 2004, the decision was made to reduce the hours of the observation facility based at the 24 hour surgery and allow General Practice to provide an observation service within their own premises. However this resulted in a reduced demand on the observation facility, and the reduced hours caused uncertainty about treatment availability.

Recently, the Christchurch Hospital opened an Acute Medical Assessment Unit (AMAU). The service is targeted at people who need to be assessed in a hospital setting and are then discharged or admitted within a 24 to 48 hour timeframe. Formerly, such patients were not confined to a specific assessment area but scattered through the hospital. The intention of the AMAU facility is to better manage people's acute care needs, which will result in an earlier discharge. Canterbury DHB has also contracted with community nursing providers, to operate an out of hours service, to assist in the discharge process.

Internal discussions indicate that the AMAU will also include the capacity to provide specialist telephone advice to General Practice and District Nursing services particularly where there is uncertainty about whether a patient could be referred to the hospital services or managed within the community. Discussions with some GPs indicated enthusiasm for this type of rapid access to specialist advice when required.

A service, which is often used in the UK, and has indicated to be a success is the placement of a general practitioner in ED. When people present at ED they are triaged,

and if it is determined that they should receive services from a General Practitioner they are referred to the general practitioner in ED. In the UK, this has proven to be successful, as people don't receive the services they expect to receive in ED and next time visit a general practitioner in the community. However there are differences between health care in the UK and in New Zealand, as general practitioner visits are free in the UK, and in New Zealand you are charged for attending general practice and after-hours clinics. Therefore there may be different reasons, such as monetary issues as to why people present at ED in New Zealand.

7.3 Reducing duplicate services

As indicated throughout this paper there is concern about the duplication of various acute care services. While one provider has access to a specific acute care team, the DHB also contracts with district nursing providers to deliver a similar service. All district nursing providers consulted during this review believe they have the skills and capacity to provide acute services, if the funding was allocated in the appropriate manner. This includes providing Home Support services.

On consulting with the sector including ED staff, other DHB staff and the ambulance service, a literature review and stakeholders group, it was considered that a mix of services needs to be put in place, as there is no one overarching solution for the range and complexity of the issues involved. The consultation provided a range of suggestions for improving services and service delivery. Most providers agreed there were levels of duplication, silo working and service gaps which, if addressed could enhance patient outcomes and reduce inefficiencies. All agreed that more could be done to keep patients in the community in the event of an acute episode though they did not necessarily agree as to how this could be done.

7.4 Increased awareness of community based acute demand management services

The increasing cost of attending after hours services may have had a negative impact on people's decisions on where to go after hours. People may also lack the understanding of when best to see a GP or attend ED. The ED reports that the pressure on its services is felt most keenly between 6pm and 8pm when hospital and General Practice services are curtailed and there is a lack of after hours services generally.

One of the issues raised by General Practice is the varying level of clarification around when they should manage a client within their practice and when they should refer them to ED. At present, due to the Acute Demand Management Programme Pegasus Health GPs are reported to have a good understanding of when to do this, while other GPs don't and feel that one way around this would be for further information and support to be provided to them. It has been suggested that this could occur by linking General Practice enquiries into the AMAU unit.

7.5 Framework of the Management of Community based acute demand management services

The DHB needs to consider a framework for the provision of acute demand services, to assist in resolving the issues identified above. This would include the following considerations:

- Access options such as alternatives to ED and after hours surgeries, nurse led initiatives and rapid response teams.
- Affordability of accessing services is still a barrier to services for all.

- Improved patient access through better coordination of community care services and better communication about the services themselves, adopt a patient centred approach and provide a service system which is seamless.
- Making the right decisions for the future requires possessing the right information. Hence, quantitative information is a key critical success factor. Currently, data quality and accessibility is a barrier to evidence based decision-making.
- Currently there is no single DHB led group responsible for the management of both internal and community acute demand services. There are a variety of projects underway, both internally and externally targeted at reducing the impact on ED, however there is little coordination of these projects. A community based Acute Demand Steering Group exists, which is made up of Secondary Care, Planning and Funding and Pegasus Health. The membership of this group is no longer representative of the wider Primary Care Sector, as PHOs are not included in this group.

In 2004 The DHB launched the Improving the Patient Journey initiative based on work implemented as part of the National Health Service (NHS) Modernisation Programme in the United Kingdom and the work programme of the Victorian Patient Flow Collaborative (VPFC) in Australia. The overarching goals of these initiatives are to reduce unnecessary waits and delays within the patient continuum of care and embed innovation tools, techniques and the learning's into other services and organisations

Key to the success of this approach is a review of the system-underpinning patient care by frontline staff that includes the following components:

- diagnostic - conduct rigorous diagnosis to identify whole system constraints.
- Innovation - develop and test innovations to minimise patient flow constraints and agree upon improvement plans.
- improvement skills building - develop service improvement skills and techniques within health services.
- mainstream - spread innovation across other clinical areas and hospitals, ensure sustainability and embed innovation practice into the service system.

7.6 Summary

During this review it has been identified that there are a number of what could be described as “blindspots” impacting on people’s access to acute care in the community. These include a number of the issues outlined above however in particular it is felt that access issues are a result of:

- A lack of community awareness of options available
- A lack of coordinated services
- Duplication of providers
- The cost to patients in attending after hours clinics
- Not all services being available to all people

The DHB needs to put services in place which would serve as a “deflection filter” to prevent people from presenting at ED inappropriately or where there are other more appropriate options available to them in the community. A potential service model incorporating a “deflection filter” is illustrated below:

8.0 ACTIONS

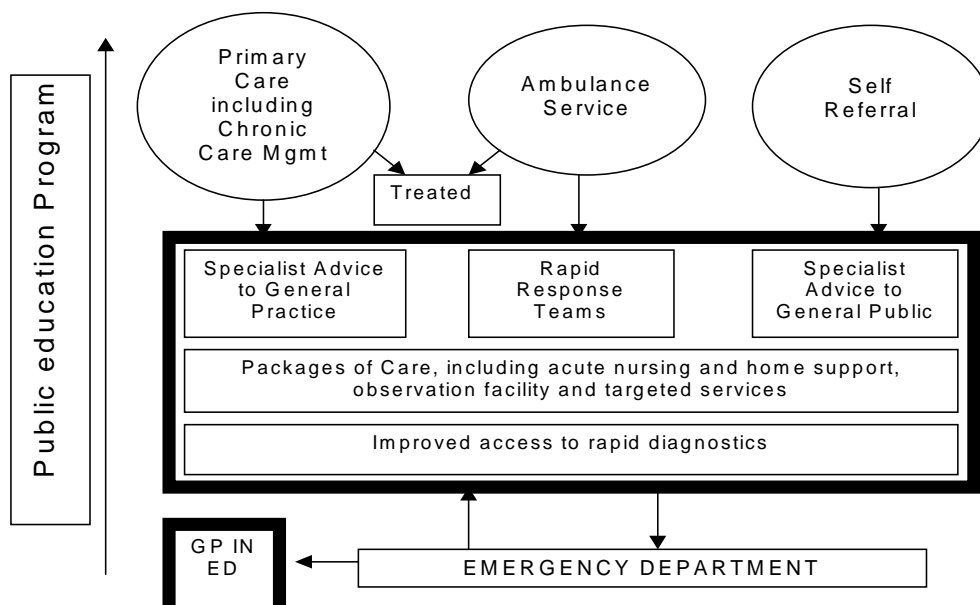
8.1 Acute Demand Management Group

There are a variety of options for the DHB to consider for the framework for acute demand services in the community, however it is suggested that the first step requires the DHB to develop a group to lead any changes. This group would facilitate the numerous acute demand projects, which are underway currently within the DHB and in the community. There is a need for:

- A stock take, coordination, monitoring and evaluation of all current acute demand projects funded by the DHB.
- An overall structure and planning framework to prioritise funding decisions going forward.
- A management group to encourage a collaborative and coordinated approach across all stakeholders, and giving consideration to the priorities and themes identified (e.g. information sharing, improved patient access and affordability).
- Data management: The importance of data emphasised in the workshops and the literature signals the need for the DHB to take the lead in defining the information requirements for acute demand services. There is a need for:
 - A stock take of current data sources (i.e. from Decision Support, the ED, the AMAU and community providers)
 - Quality data to inform decision making (i.e. identification of patterns of demand and the requirements of different patient groups)
 - Sharing information across stakeholders
 - Further follow up on the need for sharing patient data electronically.
- This group needs to be independently managed.

Action: An Acute Demand Management Governance Group and Data Management Group, included as a separate workgroup under the Improving the Patient Journey Project

There are a variety of service options that the DHB will implement, providing a systems approach to managing acute care in the community. These include the following:



8.2. Rapid Access to Expert Advice for General Practice

Discussions with the staff and the Project Manager of the AMAU see the AMAU as having capacity to provide specialist advice to GPs' through a rapid response telephone link. While the operational mechanisms including clinical protocols need finalising, it is envisaged that contact would be made through a 0800 number linking to an AMAU nurse in the first instance. This initiative together with the Nurse Led Triage described below could provide some relief for the pressure on services after hours and provide some assurance to GPs where there may be doubt as to the most appropriate clinical decision e.g. geriatrician/respiratory advice and support. This initiative could be supported by a carefully managed promotional campaign in support of this and other primary health care options.

Action: Planning and Funding will investigate further the provision of Specialist advice to GPs' from the Acute Medical Admission Unit (AMAU)

8.3 Telephone Advice Service for General Public

As indicated in the discussion section of this paper there are issues and potential area for improvement with the current Healthline services. General Practice has indicated that while generally in favour of an after hours telephone advice service, Healthline is not fully meeting the needs of consumers or local General Practice. A nurse-led after hours telephone services was trialed recently by a rural Canterbury PHO. Patients were given an 0800 number where calls were taken by a registered nurse. Practice and PHO details are available to the nurse as is the after hours roster for the local area. The nurse provides medical advice to the patient and may refer the patient to an on call GP if appropriate. Most of the providers involved in the triage pilot were supportive of its continuance and made positive comments as to how the service could be improved. If this trial were to be extended to a wider segment of the community it could be promoted through a general campaign supporting primary health care.

Action: Planning and Funding will investigate the development of a Nurse Led after hours telephone advice service. Discussions should first be held with the Ministry of Health regarding potential service improvements for the existing Healthline service.

8.4 Packages of Care

Under current agreements, some but not all members of the public have access to flexible packages of care. This recommendation is about appropriate packages of health and support care provided to patients following referral from General Practice, district nursing and the ambulance service with assessment provided through a central coordination facility. The packages include a Patient Care Plan developed and based on early intervention from a restorative perspective with the goal of reducing the onset and progression of chronic disease and disability. Depending on a patient's assessed need, packages will include any or all of the following: home support, personal care and household management.

Action: Planning and Funding will investigate the rollout of Packages of Care for the whole of Canterbury.

8.5 Acute Nursing and Home Support Services

The review process identified issues regarding acute nursing and home support. While the DHB contracts with a number of providers for these services, the structure of the service agreements mean that sections of the Canterbury population are without cover. It is believed that the development of an Acute Nursing and Home Support Team to provide care within a specific timeframe e.g. 2 to 3 hours, would have a large impact on the level of people presenting at ED, in particular being transferred there by Ambulance or from an observation service.

If an Acute Nursing Team could be put in place within a specified timeframe this would also assist on discharge, admissions and in the role of an observation facility (as discussed below). The Team would work closely with General Practice, visiting people within their homes, observation facility or hospital to action discharge. The Team would provide services for clients in the acute stage after which clients would be transferred to standard home based support services.

Action: Planning and Funding will investigate the contracting of an Acute Care Nursing and Home Support Team.

8.6 Community Observation Facility

Currently Planning and Funding contract for the provision of an observation service within General Practice. Information provided within this review suggests the observation service is under-utilised currently. It is suggested there is potential to expand the scope of this facility. Feedback from the review process identified that current services such as Dinner Bed and Breakfast, which places people within a residential facility for a period of up to two days, has a number of disincentives. It is believed that placing these people within an observation service to be supported by Acute Nursing Teams on “discharge” would be more beneficial to the needs of the patient and maintaining independence.

Referrals for an expanded observation service would be made from General Practice, District Nursing, the ED, residential care and the Ambulance Service.

Action: Planning and Funding will investigate extending the role of the Community Based Observation Facility

8.7 Service Coordination and information sharing to support the new service

Outlined during the review was the need for service coordination and information sharing between primary, community and secondary care. With the implementation of a variety of service, particularly in parts of Canterbury that may not have had access to Acute Demand Management services, there will be a need to ensure services are coordinated to reduce duplication and confusion. Information sharing will also support care management, in particularly for people with chronic conditions and on discharge from hospital.

Action: Planning and Funding will consider ways to provide coordination of service provision and reduce fragmentation in the sector. Consideration will also be given as to how to improve information sharing.

8.8 Rapid Diagnostic Service

Anecdotal evidence indicates the reason for a number of people choosing to attend the ED is their need for urgent diagnostic services, which in the past they have not been able to access speedily and without referral from General Practice except through the ED.

The recent changes in the community radiology contract should assist in making these services more accessible through General Practice and alleviate pressure on the ED, however it is felt that the potential for rapid diagnostic services needs further investigation.

Action: Planning and Funding will scope the need to improve access to Urgent Diagnostic Services.

8.9 Rapid Response

In the process of this review a number of options for rapid response and Advance Medical Practitioner services were considered. While the Advanced Emergency Care Practitioner is an effective option for the United Kingdom, where it has been implemented, it was not considered suitable for the Canterbury environment. The context for the establishment of this service is different in the UK compared to NZ in that they also provide routine services such as GP home visits and out of hours routine referrals. Additionally, the setup costs for this type of service is substantial, and not cost effective for the DHB given the more limited scope.

An alternative to this service has been the development of rapid response teams in the United Kingdom. This scheme could be likened to up-skilling the existing ambulance service paramedic staff. A rapid response team could operate out of the St John Ambulance service with calls filtered through a Call Centre or triage process. The objective would be to provide an alternative response to the Ambulance Service, which the data clearly illustrates, is the means by which the highest volume of patients arriving at the ED. Of these, many are not emergencies and could be treated by trained staff at the point of pick-up eg wounds for suturing and putting in place the Packages of Care described above.

Action: Planning and Funding will scope out the implementation of a Rapid Response Service in Canterbury.

8.10 Public Information

As agreed by ED clinicians, a significant number of ED presentations do not require emergency care or treatment and could be treated within primary care. Self referrers in particular could be targeted through a campaign promoting and encouraging patients to visit their primary health care provider rather than the hospital in the first instance. While the literature is equivocal as to the benefits of this approach, it has been used in New Zealand (Otago DHB – “Save our Emergency Department for Emergencies’ campaign) to support the implementation of other initiatives put in place to address the ‘overuse’ of the ED for non-urgent situations.

Currently the public appears to be unsure when to present at General Practice and when to present at ED. In the past, education programmes targeted at informing the Public have been seen as a success. The level of media and other publicity given to the recent junior Doctors’ strike in Canterbury also illustrates this. This publicity led to a drop in numbers of presentations at the ED with people choosing the 24 hour general practice surgery instead. This demonstrates that if the message is given sufficient prominence, people will know where to go.

Action: Planning and Funding will engage with the DHB communication team and PHOs in a Public Awareness Programme regarding "Saving the Emergency Department for Emergencies".

8.11 Aged Residential Care

Issues within residential care have been signalled as a major concern throughout this review. It has been suggested that education is required to encourage better management of acute and deteriorating health status of those in residential care rather than referring elderly patients, some of whom are also very ill to the ED.

Action: Planning and Funding will consider the needs of Residential Care facilities in regards to both contractual requirements and service requirement and work with develop system to ensure the best outcomes for clients.

8.12 General Practitioner in the Emergency Department

Regardless of what programmes you put in place, there will always be people who present at ED, who can be seen by a general practitioner. It is suggested that by placing a general practitioner in ED, and then following triage, if appropriate, these people may be redirected to the general practitioner, where they will receive general practice based services, and be charged, this will reduce the incentive for people to present at ED.

Action: Planning and Funding and the PHOs will scope the opportunity for placing a general practitioner in ED.

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