



CAMPBELL RESEARCH & CONSULTING

Review of After Hours Co-located General Practice Clinics

Prepared for

Victorian Department of Human Services

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Executive Summary

Background

In the face of increasing demand for emergency care the Department of Human Services (**DHS**) has developed a number of strategies, outlined in the Victorian Government's policy *Better Faster Emergency Care*, designed to improve access and manage demand for emergency services. The policy aims to ensure equitable and timely access to emergency care, enhance the quality of care provided, support patient centred care and deliver improved health outcomes for the Victorian community.

After hours general practice clinics co-located with public hospitals (**co-located GP clinics**), are a model of care intended to address the increasing number of Primary Care Type (**PCT**) presentations to Emergency Departments (**EDs**). Three special purpose co-located GP clinics have been established recently at the Dandenong Hospital (2003), the Northern Hospital (2005) and the Royal Children's Hospital (2006). Medicentre has been co-located with Frankston Hospital for 13 years.

The extension of co-located GP clinics was a joint initiative of the Commonwealth and Victorian Governments. The Commonwealth is responsible for funding general practice through Medicare and other initiatives. The Victorian Government is responsible for funding and policy relating to emergency care in public hospitals.

The Commonwealth's Round the Clock (**RTC**) Medicare has increased rebates for patients receiving after hours care as well as providing special purpose grants to general practices for the establishment, and ongoing support, of after hours primary medical care (**AHPMC**). This funding has been made available to co-located GP clinics as well as well located general practice clinics. The latter are clinics that provide after hours care, are located close to EDs but have no formal association with the health service or hospital.

Purpose of the Review

DHS commissioned Campbell Research & Consulting (**CR&C**) to conduct a Review of After Hours General Practice Co-located GP clinics (**the Review**). The purpose of the Review was to describe the models of care, determine the impact of co-located GP clinics on the demand for PCT services in EDs, assess the financial viability of the co-located GP clinics and their financial impact on EDs and recommend the future of this model of care in Victoria.

Findings of the Review

Service delivery models and organisational structures

Each of the co-located GP clinics was established to meet a unique constellation of local needs. Each differed in their organisational structures, relationship with the ED and hospital, governance structures and staffing mix.



Co-located GP clinics have been established to meet multiple objectives:

- To reduce demand for ED services by providing an alternative model of service delivery for low acuity PCT presentations;
- To support local General Practitioners (**GPs**); and
- To improve access to appropriate after hours medical services for patients.

The more recently established co-located GP clinics have focused on reducing demand for ED services by treating PCT patients. The co-located GP clinic at Frankston was established to support local GPs and its long-term association with the Frankston hospital has effectively reduced the number of PCT presentations to the ED resulting in a higher acuity of patients being treated in the ED.

All the co-located GP clinics are special purpose GP clinics providing emergency primary medical care for patients. Services are only provided after hours and patients are not encouraged to attend for the full range of general practice services. Continuity of care is achieved by referral to the patient's usual GP or to a local GP.

Key enablers

Enablers for success of the co-located GP clinics included: a champion within the hospital (particularly support from the ED Director); willingness and capacity of EDs to build and maintain strong relationships with the co-located GP clinics; active engagement of Hospital Executive; GP control of the co-located GP clinics; engagement with local GPs through Divisions of General Practice (**Divisions**) and GP liaison officers; proper management of the ED/clinic relationship through development and implementation of policies and management systems; confidence of ED staff in the competence of GPs to manage emergency type patients; and clear redirection criteria for ED triage staff including acceptable levels of referrals back to the ED.

The Review identified the characteristics of a well functioning co-located GP clinic to include:

- Separate, clear management and clinical governance responsibilities for the clinic;
- GP leadership within the clinic;
- Well established relationships and communication channels between the co-located GP clinic and the ED;
- Specific training around ED scope of practice and its inclusion in established continuing professional development programs for staff of co-located GP clinics; and
- The establishment of recognised quality standards.

Available evidence indicates a high level of satisfaction with services provided by the co-located GP clinics.

Barriers to full utilisation

The consultations identified that the capacity of the newly established co-located GP clinics was not fully utilised with a lower than anticipated patient throughput. The main reasons for under utilisation



included insufficient redirection of patients by the ED and poor public awareness of the co-located GP clinics. Consultation with patients in the EDs and co-located GP clinics confirmed low levels of awareness of the co-located GP clinics and patient preference for seeing a GP rather than attending an ED.

Barriers to the successful implementation of co-located GP clinics were associated with the difference in the organisational cultures of EDs and general practices – the former being a “command and control” culture necessary for managing emergency care in a large organisation, while general practices are small businesses operated by independent professionals with specialist general practice qualifications.

ED staff were concerned about clinical governance. These concerns affected the day-to-day operation of redirection of patients and were associated with the lower than anticipated patient throughput in the clinics. This has been further exacerbated by lack of clear clinical guidelines for redirection. These were barriers which stakeholders considered could be overcome.

Impact of co-located GP clinics on demand for PCT services in EDs

Evidence gathered for the Review indicates that while there has been an increase in presentations to EDs, demand by PCT patients in EDs is being contained. Presentations to EDs in Metropolitan Melbourne grew by 20% in the five years from 2001/02 to 2005/06 while the growth in PCT presentations was only 12%.

The Victorian Emergency Minimum Data (**VEMD**) indicate that growth demand for PCT presentations for after hours PCT services is lower than the growth in overall demand for ED services and growth in demand during the time when the clinics are open has been *lower* than for after hours PCT presentations. This containment occurred before the three new co-located GP clinics became operational and continued after the clinics commenced even though they have been underutilised.

Analysis of the VEMD data did not demonstrate a clear and direct impact from newly established co-located clinics. However, analysis of the clinic data suggested that the clinics were contributing to a reduction in the growth in demand for after-hours PCT services in EDs clinics by providing upwards of 20,000 services a year. This is equivalent to 10% of the total after hours PCT workload for metropolitan hospitals.

The data indicates that the growth in PCT presentations during the time when the clinics are open has been *lower* than for after hours PCT presentations as a whole. The growth demand for after hours PCT services is lower than the growth in demand for EDs as a whole.

These effects were not uniform across the clinics, with the data suggesting greater impact on demand in some clinics than others. The evidence from Frankston, in particular, indicates that a well established GP clinic which is well supported by local GPs, and where patients can directly access services, results in a lower proportion of PCT patients presenting to the ED and a higher acuity of the ED patient load.

Financial viability

The scope of the financial analysis was limited due to the availability of reliable comparable information from each of the hospitals and the co-located GP clinics. The method of capturing costs attributable to particular patients in the ED of the hospitals is limited and the data must be treated with caution.

The co-located GP clinics are not financially viable when dependant on Medicare bulk billing for funding. From the financial data provided by three newly established co-located GP clinics it is evident that the clinics would all be returning a financial loss without some form of subsidy.

The total subsidy provided by Commonwealth and State governments to each of the four co-located GP clinics during the 2005/06 year (2006/07 for RCH) varied from \$40K to \$260K. Where patient throughput was lower, the subsidy per patient was higher. Without subsidy the newly established co-located GP clinics would not be financially viable and the capacity of the established clinic to provide quality care (including a practice nurse) would be reduced.

Review of the available non-admitted patient costs attributed to after hours PCT patients in the ED provided by two of the hospitals showed that the cost of providing care in a co-located GP clinic is substantially lower than the cost of providing treatment in an ED.

Review of the costs per patient based on the total budget allocation of the Hospitals' Non Admitted Emergency Services Grant suggests that the co-located GP clinics enable each of the hospitals to save between \$1.2M - \$2.9M and improve their ED capacity to service more acute patients by 12% - 33%. It is important to recognise that these potential savings are not cash savings. Rather, they enable more efficient servicing of existing patients. For example, with a decrease in the number of less urgent patients that need to be seen in the ED, medical and nursing resources can be redirected to better service the more acute patients that present to the ED.

Strengthening co-located GP clinics will increase throughput and financial viability. Even so, they are unlikely to achieve full financial viability independent of public subsidy. In the longer term, the evidence from Frankston suggests that co-located GP clinics can be organisationally resilient and can have a positive impact on the demand for ED services while supporting the access of patients to appropriate after hours medical care. If successful, they will also result in higher acuity of ED presentations. The co-located GP clinics provide an example of the intersection of Commonwealth and State health policy and provide an opportunity for the improved integration between the two levels of government.

Future Directions

The existing co-located clinics need to be strengthened to ensure greater utilisation of potential capacity and to provide appropriate, cost-effective after hours emergency services to the Victorian community. There are also opportunities to strengthen the role of well located clinics.

Hospitals and well located clinics operating in their catchments can improve community access to appropriate after hours medical care by developing closer relationships.



New co-located clinics can be considered where there is a local need identified by high demand for ED services by PCT patients, low levels of after hours service provision by local practices and support for both referral to, and roster participation in, co-located clinics by local practices.

The support of local GPs, both through referral of patients and participation in rosters, is a vital ingredient for success and ongoing viability of the model. There is also a clear need for clear redirection guidelines for triage staff in EDs and the development of practice standards to facilitate ongoing quality improvement.

New co-located clinics can be considered where there is a local need identified by high demand for ED services by PCT patients, low levels of after hours service provision by local practices and support for both referral to, and roster participation in, co-located clinics by local practices.

Hospitals and well located clinics operating in their catchments can improve community access to appropriate after hours medical care by developing closer relationships.

A common evaluation framework is required for the co-located GP clinics to monitor their utilisation, financial viability, quality of care and the impact of the clinics on the demand for after hours PCT services in EDs. Monitoring should also include the newly established well located clinics, particularly as current Commonwealth funding is time limited. There is little likelihood that special purpose after hours GP clinics can provide safe, quality services and be financially viable while providing services that are of an appropriate quality without some form of subsidy.

Co-located GP clinics have the potential for achieving the goals of both Commonwealth and Victorian Government policy to strengthen the integration of hospitals and general practices. Greater integration between the two levels of government would enhance the provision of after hours primary medical care for the Victorian community.

The development of general practices that are either co-located or well-located requires the ongoing collaboration of the Victorian and Commonwealth Government, particularly as it is not considered likely that single purpose after hours clinics will be financially viable without subsidy.

Conclusion

This Review has identified that the co-located GP clinics have not reached their full utilisation and, at best, are reducing the rapid increase in demand for PCT presentation to EDs. They are not currently financially viable and are unlikely to be financially viable without government subsidy either from DHS or the Commonwealth. There are opportunities for strengthening the co-located GP clinics which, even with subsidy are, more cost-effective than treating PCT patients in EDs.

Co-located GP clinics can play an important role in the cost-effective and appropriate management of ED demand and provide the opportunity to strengthen the relationship between EDs and community based general practice. Monitoring is required to ensure that the co-located clinics are achieving their objectives and there are no disincentives to ED redirection to the co-located clinics.

Recommendations

Recommendation 1: Commonwealth-State interface

That DHS continue to work with the Commonwealth to develop long term strategies that can ensure after hours primary medical care is provided to the Victorian community. These strategy could include, but may not be limited to the:

- Collaborative planning processes for identifying, developing and funding of after hours primary medical care;
- Development of appropriate redirection processes;
- Facilitation of opportunities for GPs to work in EDs;
- Commissioning of research to improve understanding of the drivers of consumer decision making; and
- Exploration of mechanisms to improve the referral of appropriate patients from local general practices to EDs, including referrals to co-located GP clinics, with particular emphasis on the availability of services after hours.

Rationale

Co-located GP clinics provide a unique opportunity for the Victorian and Commonwealth Governments to work co-operatively in the long term planning to strengthen the relationships between hospital EDs and general practice to improve consumer access to appropriate after hours medical care.

Recommendation 2: Strengthening existing co-located GP clinics

That DHS strengthen the existing co-located GP clinics by:

- Ensuring co-located GP clinics have distinct governance arrangements with appropriate GP leadership and clear lines of communication between each clinic and its associated ED;
- Working with EDs and co-located GP clinics to develop clinically relevant, proactive guidelines for appropriate redirection of patients between EDs and co-located GP clinics; and
- Developing a comprehensive minimum data set to enable the monitoring of co-located GP clinic performance as a requirement of funding.

That hospitals with existing co-located GP clinics strengthen those clinics by:

- Enhancing the salience and visibility of the clinics and implementing effective communication strategies to facilitate *appropriate* community access;
- Ensuring that co-located GP clinics are not inappropriately perceived as offering alternative full general practice services;
- Working with Divisions and GP Liaison Officers to encourage local general practices to refer patients to the co-located GP clinics, to improve appropriate redirection and

confirm the continuity of care by notifying GPs when their patients attend a co-located GP clinic;

- Encouraging local general practices to support the co-located GP clinics by offering them opportunities to participate in rosters and promoting the availability of appropriate after hours support;
- Contributing to the development of specific training for GPs working in co-located GP clinics and offering opportunities for GPs to participate in ED continuing professional development programs; and
- Promoting the establishment of shared quality assurance and improvement programs including audit of the appropriateness of redirections.

Rationale

The consultations identified a number of barriers that have prevented the existing new co-located GP clinics from realising their full potential. There are distinct organisational cultures that have the potential to work together. Clarification of organisational structures, improved communication and specific training will be key factors in overcoming the existing barriers to success.

Recommendation 3: Definition

Co-located GP clinics are defined as “*general practice clinics located in or near hospitals that are funded directly or indirectly by either DHS or the health service*”. Well located clinics are those located in or near hospitals receiving no direct or indirect funding from either DHS or the health service.

Rationale

Notwithstanding the need for broader cooperation with the Commonwealth, Divisions and general practices, DHS should clearly distinguish clinics where the Victorian Government has direct interest and influence.

Recommendation 4: Primary purpose of co-located GP clinics

That DHS clarify that the *primary* purpose of co-located GP clinics is to provide an alternative model of care that will improve access to GP type services and reduce demand for after hours PCT services in EDs. Support for local general practices remains an important consideration.

Co-located GP clinics have a range of important objectives including: improving community access to services; providing quality services; and supporting local general practice. Identifying the primary purpose provides a clear guideline for policy development and a basis for the evaluation of effectiveness.

Rationale

Funding by DHS, the defining characteristic of co-located GP clinics, can be justified in managing ED demand.



Recommendation 5: Well located GP clinics

That health services and hospitals be encouraged to develop formal ongoing relationships with local general practices to support co-ordination of services, to provide systematic access to appropriate after hours emergency care to the local community through well located GP clinics.

Rationale

The evidence obtained in the course of this Review has indicated that co-located GP clinics are one option that can reduce ED demand where there are insufficient resources in general practice in the community to provide after hours services. Encouragement of support by health services and hospitals for local general practices to provide services to integrate with those offered by the hospitals will be a benefit to all stakeholders.

Recommendation 6: Establishing new co-located GP clinics

That new co-located GP clinics be considered *only* in areas where there is:

- Verified shortage of existing after hours general practice services;
- High demand for ED services by patients in the after-hours period who could be suitably treated by GPs;
- Clear commitment from the health service; and
- Support from local Divisions and general practices in the form of referrals to, and staffing of, the co-located GP clinic.

These factors are necessary to achieve the long term organisational viability of single purpose after hours co-located GP clinics.

Rationale

Co-located GP clinics may be appropriate where there are high levels of presentations to EDs that could be considered PCT patients and insufficient after hours general practice services in the community. Support by local general practices through Divisions and strong commitment by ED leadership to ongoing support for the co-located GP clinics are necessary for the long term viability of co-located GP clinics.

Recommendation 7: Enhancing support of AHPMC

That DHS support community access to AHPMC by strengthening the relationships between health services and general practices through the GP Liaison Program and Divisions. Specific areas to be considered include:

- Identification of existing after hours general practice services in ED catchments;
- Informing consumers of available after hours general practice clinics through telephone triage services, such as Nurse-On-Call;

- Developing specific information for consumers about appropriate choices for after hours medical care; and
- Facilitating regular communication between EDs and Divisions in regard to local issues in the provision of AHPMC.

Rationale

The DHS policy *Care in your community* emphasises integration with the community as an important DHS policy direction. The GP Liaison Program has a key role in building strong working relationships between hospitals and general practice to promote sustainable collaboration and partnership between the services. One of the key performance indicators for Divisions is integration with acute hospitals. Divisions, co-ordinated through the General Practice Divisions - Victoria (**GPDV**). Together these programs are effective vehicles to integrate general practices and emergency services.

Recommendation 8: Continuing evaluation

The DHS lead the development and implementation of a common evaluation framework including a minimum data set (Recommendation 2) for co-located GP clinics to monitor their:

- Impact on the demand for after hours PCT services in EDs; and
- Financial viability, patient throughput and quality of care as measured through appropriate standards including patient satisfaction.

Rationale

Evaluation against agreed objectives is a critical aspect of ensuring resources are used effectively and efficiently. Apart from Frankston, the co-located GP clinics have not achieved full utilisation. This has impacted on their potential for maximising financial viability. Making the continued operation and funding of co-located GP clinics by DHS contingent on improvement in utilisation against specific goals set in consultation with each co-located GP clinic will ensure the Department is funding effective solutions.

Recommendation 9: Establishing standards

That DHS work with health services, GPDV and the Royal Australian College of General Practitioners (**RACGP**) to identify appropriate practice standards for single purpose after hours GP clinics, including relationships with EDs, to facilitate a formal quality assurance program.

Rationale

Quality assurance is a key element of ensuring safety and quality of service delivery. Establishment of standards against which a service can be evaluated is a key element of this process. Current accreditation standards are not readily applicable to single purpose and other after hours GP clinics. The RACGP is the appropriate body to identify standards for general practice services.

Recommendation 10: Impact on Non-admitted Emergency Services Grants

That DHS review the impact of co-located GP clinics on health service funding to ensure there are no disincentives for EDs to offer appropriate patients the option of attending co-located GP clinics.

Rationale

The evidence from Frankston is that an established co-located GP clinic, supported by local GPs, is associated with a lower proportion of PCT presentations to EDs resulting in higher acuity of ED presentations. It can be inferred that successful operation of co-located GP clinics will result in reduced numbers and increased acuity of presentations to EDs.

While the increased acuity is compensated in the existing funding structure, reduced ED presentations may result in a reduction in the Non-admitted Emergency Services Grants thereby creating disincentives for EDs to offer appropriate patients the opportunity to attend the co-located GP clinics even if this is a more suitable option.

Recommendation 11: Minimise the likelihood that a non-delegable duty of care will be held to exist

That the following actions be taken to reduce the risk that a non-delegable duty of care will be held to exist where a general practice is governed independently of the co-located hospital:

- Hospitals should make it clear to patients that the co-located GP clinics are operated independently of the hospital, by persons or organisations other than the staff of the hospital;
- Protocols should be agreed between the hospital and the co-located GP clinic as to how the relationship will be explained to patients; and
- Signage and written information should explain clearly the relationship between the general practice and the co-located hospital.

Recommendation 12: Ensure effective clinical governance

That the hospital's clinical governance systems be applied where a general practice clinic is governed by the co-located hospital. Where a general practice is governed independently of the co-located hospital, agreements between the parties should address:

- The standards that will apply to clinical care, including advice on service options that will be provided by each party;
- The clinical risk management, quality monitoring and accountability mechanisms that will apply;
- The insurances that will be held; and
- The way in which the parties will share information relevant to clinical quality and address clinical quality concerns.

Rationale

That DHS consider sponsoring a project to develop a clinical governance template to be applied by hospitals and general practices developing co-location agreements as part of the process of strengthening co-located GP clinics.

The simplest method of ensuring that appropriate clinical governance systems are adopted by both parties in situations where the co-located practice is independent of the hospital would be via contractual agreements associated with the lease or licensing of hospital facilities to the co-located general practice. If a co-located general practice is operating in facilities that are not owned by the hospital, the legal mechanisms for effecting relevant agreements will vary but the standards, intent and outcomes of such agreements should not.

Terms and acronyms used in this report

After hours (DHS definition)	Before 8.00 am or after 6.00 pm on a weekday, before 8.00 am or after 12.00 pm on a Saturday, or anytime on a Sunday or public holiday
AHPMC	After hours primary medical care
Co-located GP clinics	After hours co-located general practice clinics. For the purpose of this report, <i>co-located GP clinics</i> refer to the four clinics at Dandenong, Frankston, Northern and the RCH specified in the request for tender
Dandenong	The Dandenong Hospital which is part of Southern Health
Divisions	Divisions of General Practice
DHS	Victorian Department of Human Services
ED	Emergency Department
Frankston	The Frankston Hospital
GP	General Practitioner
GPDV	General Practice Divisions – Victoria Ltd
HDMS	Hospital Development Management Strategy
KRMC	Keilor Road Medical Centre
MHS	Metropolitan Health Strategy
NESG	Non-admitted Emergency Services Grant
Northern	The Northern Hospital
PCT	Primary Care Type
RACGP	Royal Australian College of General Practitioners
RCH	Royal Children’s Hospital
Redirection	“Redirection” is used to describe the triage nurses recommending patients consider attending a co-located GP clinic. It is not considered a formal referral.
RTC	Commonwealth Government Round The Clock (Medicare) Funding Program
VEMD	Victorian Emergency Minimum Data

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1. This Review

The Department of Human Services (**DHS**) is responsible for setting the policy direction and funding for emergency services in Victorian public hospitals. Demand for emergency services, measured by presentations to Emergency Departments (**EDs**) has been increasing since 2001/02. This increase has occurred at a faster rate than can be accounted for by population growth and demographic changes associated with an ageing population.

The Victorian Government policy for emergency services set out in *Better Faster Emergency Care* identified a range of strategies for reducing demand and improving management of patient throughput. The policy foreshadowed that a review of after hours general practice clinics co-located in public hospitals (**co-located GP clinics**) would be undertaken early after the implementation of the services in Victoria.

In March 2007, DHS commissioned Campbell Research & Consulting (**CR&C**) to undertake the Review of After Hours General Practice Co-located GP clinics (**the Review**). The Review focused on the four metropolitan after hours general practice clinics described as co-located. These were at Dandenong, Frankston, the Northern and the Royal Children's Hospitals (**RCH**).

The primary objectives of the Review were to:

1. Describe the various service delivery models and types of organisational structures and processes established to govern and manage co-located GP clinics and assess their business and financial viability;
2. Establish the financial impact and staffing implications of co-located GP clinics on hospital EDs;
3. Provide recommendations about the future of co-located GP clinics in the context of a range of emergency Primary Care Type (**PCT**) services and current and future Commonwealth and State policy directions;
4. Understand the relationship between after-hours general practice service provision and the utilisation of hospital ED services including:
 - reviewing the trends in ED utilisation in Victoria and determine the impact of co-located and well located after hours general practice clinics in reducing the demand for PCT services in hospital EDs;
 - identifying the relationships that currently exist between hospitals and after-hours general practice clinics and make recommendations about procedures and processes for developing the relationships and establishing formal service linkage agreements between hospital EDs and after-hours general practice; and
 - exploring consumer preferences and satisfaction with co-located GP clinic services and the influence of ED staff attitudes on the redirection of consumers from EDs to co-located GP clinics. Identify and make recommendations about the processes in place in hospital EDs to ensure patients are offered an informed choice of treatment options.

This report presents the findings of the Review of these co-located GP clinics conducted by CR&C with RSM Bird Cameron and DLA Phillips Fox. It reviews the policy context affecting public hospital EDs and general practice presents findings from consultations conducted with EDs, co-located GP clinics, well located clinics and patients; provides an analysis of the financial viability of the co-located GP clinics and sets the context in an analysis of the Victorian Emergency Minimum Data (**VEMD**).

2. Methodology

CR&C used a number of different methodologies to address the objectives of the Review.

The primary source of information relating to the implementation and operation of the co-located GP clinics was a series of in-depth consultations with key stakeholders associated with the four clinics specified in the RFT. Less detailed consultations were undertaken with well located clinics. The VEMD was analysed to identify demand for PCT services in EDs and to determine if there was any impact associated with either the co-located or well located clinics. Detailed financial information was provided by co-located GP clinics that received DHS funding to enable analysis of financial viability. An analysis of clinical governance issues was undertaken to inform the future directions of the co-located GP clinics.

2.1 Consultations

Key stakeholders associated with co-located GP clinics who were consulted included hospital management; ED directors and other staff in EDs; General Practitioners (**GPs**); Divisions of General Practice (**Divisions**); co-located GP clinic practice management staff; and patients attending EDs and co-located GP clinics.

Less detailed consultations were conducted with two of the four well located clinics that agreed to participate in the Review. Separate consultations were held with the General Practice Divisions – Victoria (**GPDV**), the State Based Organisation representing all Victorian Divisions, and DHS officers.

A workshop with stakeholders was held on 4 June 2007 to present and confirm preliminary findings.

2.2 Analysis of the VEMD

Five years of VEMD from 2001/02 to 2005/06 were analysed to identify the extent of demand for PCT patients and any impact associated with the establishment of the co-located GP clinics.

Commencing with an analysis of after hours PCT patients based on the DHS definition, the analysis was refined to focus on presentations during co-located GP clinic opening times.

2.3 Financial analysis

A quantitative analysis of available financial data from the four co-located GP clinics and related EDs was undertaken by RSM Bird Cameron. This entailed:

- Review of the financial data (profit and loss) provided for three co-located GP clinics for the 2005/06 financial year. This review assessed the financial viability of the co-



located GP clinics by analysing the clinics' patient throughput and profitability. The data provided by each co-located GP clinic varied in format, as did the available related patient data; therefore each co-located GP clinic was independently assessed;

- DHS requested each of the hospitals extract data with costs for non admitted patients that conformed to the DHS definition of an after hours PCT patient. These data are not utilised by the hospital management nor reviewed by DHS. The results of the analysis were reviewed against co-located GP clinic based data to estimate comparative of costs for the hospitals and the respective co-located GP clinics. These data were only able to be extracted by two of the hospitals. These costs were compared to the direct costs identified in the analysis of the co-located GP clinics financial data;
- Identification of the level of subsidy and funding received from the State and Commonwealth to identify the amount of subsidy per patient by dividing the subsidy by the number of patients treated in the co-located GP clinic during the year;
- Using the total budget allocation for the hospitals Non-Admitted Emergency Services Grant (**NESG**) to analyse the cost per patient for each of the EDs. Using the after hours PCT patient numbers in the EDs and the actual number of patients treated by the co-located GP clinics the potential savings in capacity and costs for each of the EDs was determined.

2.3.1 Quality of financial data

The scope of the financial analysis was limited due to the availability of reliable comparable information from each of the hospitals and associated co-located GP clinics. Each of the co-located GP clinics has a different governance and management structure. Therefore the availability and quality of information varied. The Frankston co-located GP clinic did not provide financial data to enable the team to assess financial viability. Inferences for that co-located GP clinic have been based on its long term operation and the assumption that the GPs owning and working in the clinic would only do so for reasonable recompense.

Some of the desired analysis and comparisons have not been possible due to limited information received.

The consulting team has reservations about the quality of the financial data provided by the hospitals from which the cost per non-admitted PCT patient was calculated for use in this report. However, it is recognised that this is the only available source of data on costs of PCT patients in EDs. It has been used as the best available estimate. Further work is required to confirm the validity and reliability of these data.

2.4 Clinical governance review

DLA Phillips Fox assisted with analysis of clinical governance issues and provided high level advice on relevant legal issues. The clinical governance analysis has been included as Appendix 1.

3. The policy context

The provision of services to PCT patients in EDs is an area where the Commonwealth and State government policy frameworks intersect. The 2003 Australian Health Care Agreement (**AHCA**) between the Commonwealth and State governments identified the hospital-GP interface as an area for reform (Commonwealth Department of Health and Ageing, 2003).

Co-located GP clinics are special purpose general practice clinics that provide after hours primary medical care for patients. They are located within public hospitals and are intended to provide an appropriate alternative for PCT patients who present to EDs.

3.1 Primary medical care

Primary medical care in Australia is provided predominantly by general practices. The Royal Australian College of General Practitioners (**RACGP**) defines general practice as:

“the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.” (The Royal Australian College of General Practitioners, 2007)

The Commonwealth Government, through the Department of Health & Ageing (**DoHA**) funds general practice and has been responsible for policy in regard to after hours primary medical care (**AHPMC**).

Funding of after hours general practice services has been primarily through Medicare rebates. More recently Round the Clock (**RTC**) Medicare has provided grants for the establishment and improvement of after hours general practice services as well as increasing the Medicare rebates for after hours care. Three co-located GP clinics in scope of this Review have received RTC funding.

The Commonwealth also makes Practice Improvement Payments (PIP) available to general practices to reward quality improvement. These payments are linked to the provision of after hours care by eligible practices. The co-located GP clinics are not eligible for PIP because they do not provide 24 hour care and are not able to be accredited as meeting the standards for general practice required for these payments.

Divisions are funded by the Commonwealth to support general practice and assist in the implementation of national primary health initiatives. Through State Based Organisations (GPDV in Victoria) Divisions have been actively involved in state government primary health initiatives. One of the National Performance Indicators for Divisions is integration of general practice with acute hospitals. Provision of after hours services and co-located GP clinics are important initiatives for Divisions to achieve their objectives. In Victoria, some Divisions have taken on the responsibility for managing after hours clinics while others have supported general practices through development of other initiatives including co-located GP clinics.

Co-located GP clinics provide emergency *after hours* primary medical care. This care is usually episodic with each patient being a new patient with limited opportunity for providing continuing care by the co-located GP clinic. Continuity of care for patients is achieved through redirection to other practices.



3.2 Emergency care

The policy for emergency care in Victoria is developed by **DHS** and implemented through the public hospitals. Emergency medicine is defined by the International Federation for Emergency Medicine as:

“a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury.”(International Federation for Emergency Medicine, 1991)

In Victoria, emergency care is provided primarily by EDs of public hospitals.

Provision of high quality, accessible health and community services is one of the ten shared goals of the Victorian Government’s vision for Victoria outlined in *Growing Victoria Together* (Victorian Department of Human Services, 2005). Better access to hospital services, including emergency services, is part of this goal and access to these services is a priority for the Victorian Government.

DHS’s *Metropolitan Health Strategy (MHS)* released in 2003 (Metropolitan Health and Aged Care Services Division, 2003), outlined the Victorian Government’s strategy for managing changing trends in services and challenges facing the health system. Complementing existing policies, such as the Hospital Development Management Strategy (**HDMS**) the MHS set out a framework for managing the fundamental system changes required for Victoria’s health system to meet growing and changing demand. The MHS set the foundation for a new approach to ambulatory care services, emphasising the need for a community based health system. The policy outlined a commitment to making existing care options more accessible to users through a number of initiatives, including developing new service models, and service substitution and diversion through promoting effective care alternatives.

Care in your community: A planning framework for integrated ambulatory care policy (Victorian Department of Human Services, 2006) emphasised the Victorian Government’s commitment to creating an integrated, person and family focused community based health care system. This policy outlined the importance of integrating different health services, encouraging partnerships and collaboration between different levels of government, different medical professions and public and private health providers to create community based care services. The provision of after hours care through co-located GP clinics serves as an important element of this policy, in that the clinics are a prime example of how services, general practices and hospitals can be brought together to *“improve convenience, accessibility, quality of care and efficiencies”* (Victorian Department of Human Services, 2006) within the Victorian health care system.

Better Faster Emergency Care (Victorian Department of Human Services, 2007) sets the Victorian Government’s policy direction for improving emergency medical services in the Victorian health system. The policy implemented by DHS has identified service options to be developed to ensure equitable and timely access to emergency care, enhance the quality of care provided, support patient centred care and deliver improved health outcomes for the Victorian community.

The service options include:

- Developing new services options (including co-located GP clinics, emergency primary care centres and Nurse-On-Call);
- Improving coordination between EDs and ambulance services;

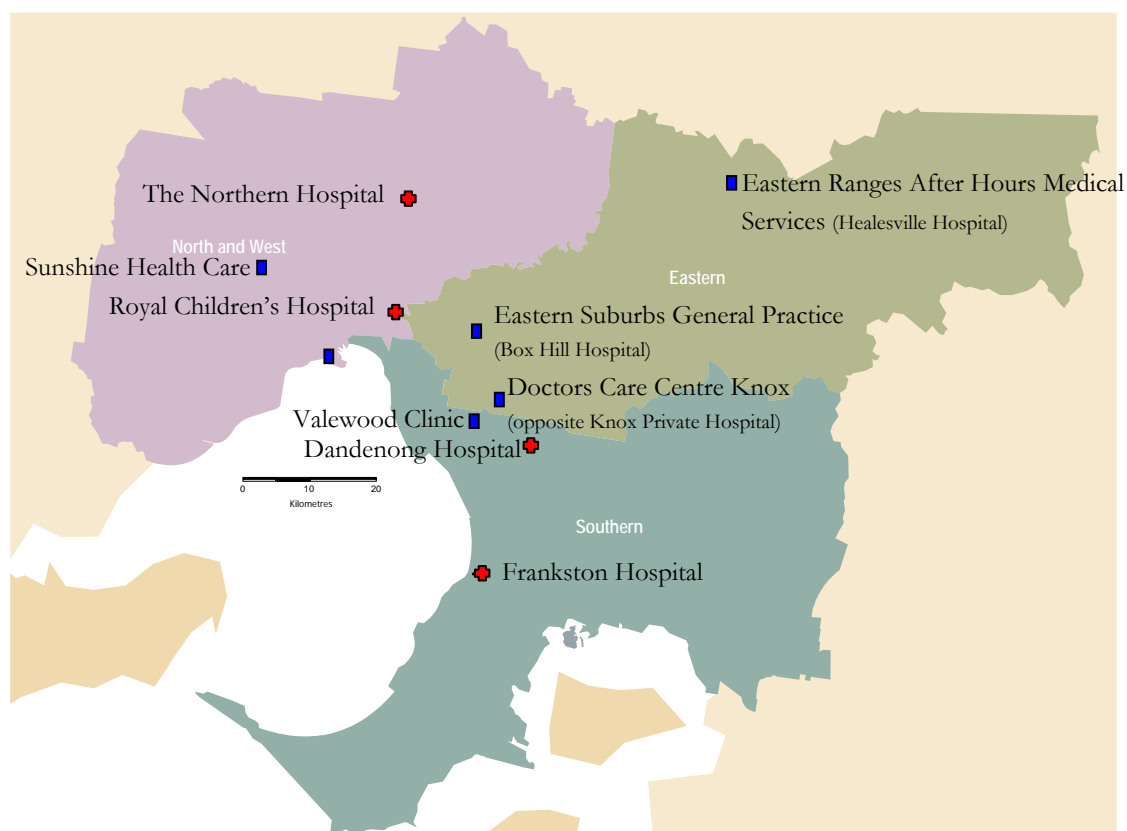


- Improving the patient experience;
- Mainstreaming new models of care (including Fast Track and enhanced triage services);
- Exploring new ways of working;
- Enhancing safety and quality of care;
- Promoting better systems of care;
- Promoting better management of care for people with mental health problems;
- Promoting better management of care for older people; and
- Promoting better management and care of children.

A range of strategies have been developed by hospitals and DHS in collaboration with other service providers including general practices. The provision of after-hours medical care has been identified as one area where there is potential for reducing demand on ED services.

DHS has funded the establishment of co-located GP clinics at three Victorian hospitals, Dandenong Northern Health (**Northern**), and the RCH (Figure 1). The clinic at Frankston was established and co-located for some time before the current policy framework was implemented. The co-located GP clinics at Dandenong, Frankston and Northern have received RTC Medicare funding from DoHA.

Figure 1: Metropolitan hospitals with co-located GP clinics and well located clinics



Well located clinics have been recently established near Healesville hospital, Knox private hospital and Sunshine hospital. These clinics have not been considered in the analysis for this review because of the early stage of their development and the fact that they are not receiving DHS funding. The Eastern Suburbs General Practice has been established for some time but moved to premises that are “well located” to Box Hill Hospital in January 2006.

3.3 Primary medical care

‘After hours primary medical care’ is medical care provide outside opening hours of general practices. For this project the DHS definition has been used “*before 8.00 am or after 6.00 pm on a weekday, before 8.00 am or after 12.00 pm on a Saturday, or anytime on a Sunday or public holiday*”.

In January, 2005 the Commonwealth introduced Round the Clock (**RTC**) Medicare to subsidise the establishment and operation of AHPMC services. Part of this package included increased Medicare rebate for urgent after hours care provided by GPs (Medicare Australia, 2007).¹

Provision of after hours care is an important element in meeting the standards established for quality general practice. Accreditation reflects the extent to which a practice meets quality standards. The accreditation requirement for provision of after hours care can be met through a number of approaches including rosters (or cooperative care), the use of deputising services and “*arrangements with a local hospital or other after hours health care facility*” (The Royal Australian College of General Practitioners, 2000).

The number of GPs providing direct after hours care has fallen. This fall has been associated with the changing structure of the general practice workforce, particularly the pressures of meeting demand for services in hours, the increased number of female GPs, an increasing proportion of GPs becoming employees and lifestyle choices. The provision of after hours care is considered to create health and safety risks and impact on family life for GPs. While most general practices meet the standard of providing access to after hours care, the number of general practices providing their own or cooperative after hours care has been declining. In 2005/06 less than half (47%) of GPs participating in the Bettering the Evaluation And Care of Health (BEACH) study reported providing their own or cooperative (rostered) after hours care, a decline since 2001/02 when 56% reported such arrangements (Britt, 2007).

3.4 Current models of after hours primary medical care

There are three main models of service delivery for AHPMC which are based on the location where the service is provided. These are treatment at: a general practice clinic; at the patient’s home; or at a hospital ED. Co-located GP clinics are a particular instance of special purpose after hours care.

Patients generally self refer to general practices, attend an ED after hours, or call a deputising service where a GP will attend the patient at home. Some patients are directed to after hours services by general practice either through answering machines or signage. More recently, telephone triage services

¹ “Urgent” after hours GP services for which the rebate was increased under RTC Medicare services provided before 8 am and after 8 pm weekdays, after 1 pm on Saturday and any time on a Sunday or public holiday.

such as Nurse-On-Call have been introduced to provide advice to consumers about the availability of medical services appropriate to their needs. There is currently no comprehensive information mapping consumer pathways to after hours services or research identifying the basis of patient decision making in regard to after hours care.

The service location models are:

1. *General practice clinics operating as:*

Extended hours general practice clinics most commonly offered by larger practices in metropolitan and larger rural centres which are staffed by five or more GPs with after hours services provided through a roster of staff.

Special purpose after hours general practice clinics including clinics that are **co-located** with a hospital offering after hours emergency services, or **well located** to such hospitals. These special purposes general practice clinics provide limited AHPMC.

Roster systems based in a hospital or general practice clinic have been a common feature of AHPMC in rural regions. Less commonly used in metropolitan regions, roster systems generally include a number of practices committing to provide after hours care. The Frankston co-located GP clinic is staffed through a roster system of local practices.

2. *Home visits by GPs*

Home visits are most commonly delivered through medical deputising services (frequently referred to as locum services). Some GPs will perform home visits for patients in their practice who may require after hours care. Very few GPs in Melbourne offer home visits to all patients.

3. *Patients attend hospital EDs*

While EDs in metropolitan hospitals are not designed specifically for providing general practice type services, they do provide 24 hour access to medical services at no cost to the patient.

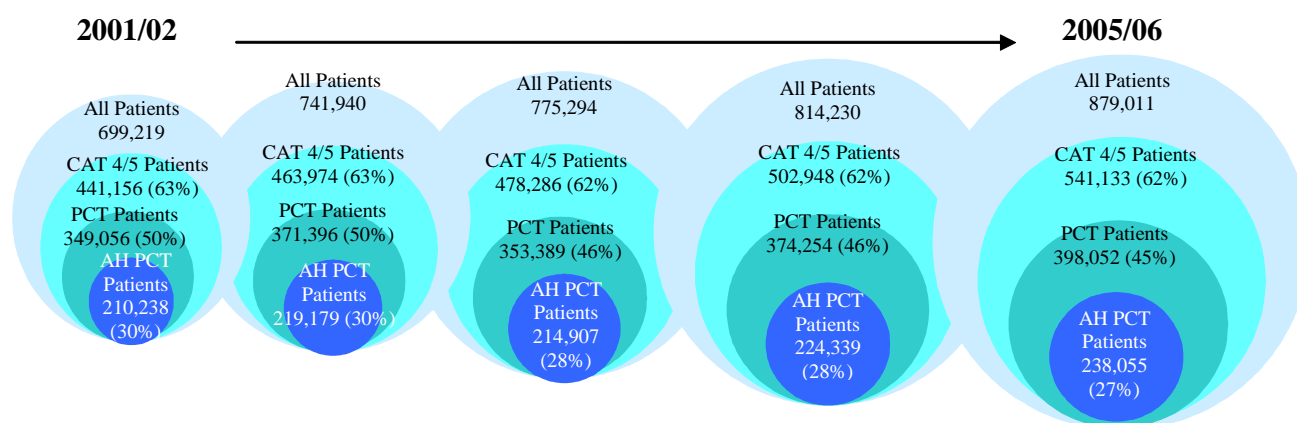
4. Demand for after hours medical care

Demand for emergency care by consumers has been increasing across Australia. The Auditor General's 2004 report (Victorian Auditor General, 2004) identified that while the metropolitan health services were responding well to increasing demand, there was room for improvement particularly in clinical supervision of waiting rooms and for patients who presented to EDs but who left before being treated. New co-located GP clinics have been funded by DHS in the context of introducing new models with the aim of reducing the demand for services in EDs.

In 2005/06 there were 1,247,060 presentations to EDs in Victoria of which 879,011 were in metropolitan hospitals.

Nearly half (45%) of the presentations to metropolitan EDs were PCT patients while 27% were *after hours* PCT patients (Figure 2). Of all ED presentations 59% were after hours.

Figure 2: Composition of ED presentations to all metropolitan hospitals



Base: Presentations to EDs in Melbourne public hospitals

Total demand for ED services in metropolitan Melbourne has increased by 20% over the five years from 2001/02 and 2005/06. This increase is far larger than the growth in population.

The absolute demand for after hours PCT services increased between 2001/02 and 2005/06 by 27,817 episodes or 12% over the five years from 210,238 to 238,055.

Relative demand (the proportion of all ED presentations) has declined by 3% over the same period from 30% in 2001/02 to 27% in 2005/06.

There were approximately 23,400 PCT patients treated after hours in the three co-located GP clinics operating in 2005/06. This is equivalent to an additional 10% of the total after hours PCT workload for metropolitan hospitals for that year.

A national survey of Australian consumers conducted in 1999 and 2000 (Campbell Research and Consulting, 2001) found that 13% of Australians aged 16 years or over had used after hours medical services in the previous year. EDs were the most frequently *used* while medical clinics, followed by home visits, were most frequently identified as the *preferred* location. Using the proportion of Victorians reporting the need for after hours medical services it can be estimated that in 2005/06, 671,500 Victorians used medical services after hours. It is not known what proportion of have multiple episodes or presentations. Data for use of general practice services and ED attendances is based on episodes of care (consultation or presentations) not the number of persons or patients.

5. Impact of co-located GP clinics – analysis of VEMD data

The VEMD contains de-identified demographic, administrative and clinical data detailing presentations at Victorian public hospitals with 24-hour EDs. Analysis of the VEMD data for Melbourne Metropolitan EDs was conducted to assess the impact that the co-located GP clinics have had on demand for ED services, and performance of EDs in managing services for PCT patients.

5.1 In summary

Based on analysis of VEMD data, limited conclusions can be drawn regarding the impact of after hours clinics on demand and quality of ED services over the five years to June, 2006.

The introduction and operation of co-located GP clinics were associated in some reduction in demand, and appeared to be slightly related to an improvement in services in EDs. These effects were most apparent for the Dandenong Hospital, and to a lesser extent, Northern Hospital. The co-located GP clinic at the RCH was established after the analysis period. Frankston has been established and no change would be expected. However, comparative analysis demonstrates the long term effect on both presentation and ED acuity associated with the Frankston clinic.

Specifically:

- In relation to demand:
 - Overall, demand for after-hours PCT services has increased over the last five years for all Melbourne metropolitan hospitals. Some impact on demand was shown in relation to the operation of co-located GP clinics: demand for PCT services during clinic hours has also increased, but at a lesser rate; and
 - The introduction of co-located GP clinics was associated with a reduction in demand for the Dandenong Hospital, and to a lesser extent, Northern Hospital. No clear change in demand over time was apparent for Frankston Hospital, nor the RCH. The re-location of a well-located clinic at Box Hill was associated with a decline in demand for PCT services.
- In relation to performance:
 - The presence of a co-located GP clinic appeared to be associated with a slight decline in waiting times for the Dandenong Hospital, and for a lesser extent, the Northern Hospital. Frankston and the RCH were established before and after, respectively the analysis period and therefore could not be included in any impact analysis. Little impact was seen for all other hospitals, including the well-located clinic at Box Hill;
 - The presence of a co-located GP clinic was associated with an increase in the proportion of PCT patients treated in target time increased in 2003/04 for Dandenong and Northern Hospitals. The introduction of clinics at other hospitals appeared not to be related to an increase in performance in this regard; and

- A slight reduction in the proportion of PCT patients leaving before treatment was observed for the Dandenong and Frankston Hospitals following the introduction of the clinics. No substantial change was observed for the other hospitals.

However, further analysis should be undertaken when 2006/07 VEMD data is available to confirm these trends at the RCH.

It should also be noted that confounding factors such as other initiatives at the hospitals in question limit the evaluation team's ability to draw firm conclusions of the impact of co-located GP clinics based on VEMD data alone.

5.2 Overview of the methodology

The results presented in this section are based on analysis of the VEMD for five full financial years. The VEMD for Metropolitan Melbourne public hospitals was provided to CR&C by the DHS as de-identified unit record information. Analysis was undertaken on demographic and administrative data fields to inform this Review.

The data used for the analysis:

- Included complete data subsets for the financial years between 2001/02 and 2005/06;
- Focused on after hours presentations based on the DHS definition of after hours, and/or presentations at a time when co-located GP clinics were open. The *most common clinic opening hours* were identified as: Monday to Friday – 6 pm to 11 pm, Saturday – 1 pm to 11 pm, and Sunday/Public Holiday – 10 am to 11 pm; and
- Focused on PCT patients.

Two primary forms of analysis were conducted using the VEMD data: an assessment of the impact that the co-located GP clinics had on *demand* for services, and the impact that co-located GP clinics had on *performance* of EDs.

➤ **Demand:**

Change in demand for hospital services was assessed in two ways:

- The number of PCT patients presenting to EDs during co-located GP clinic hours. A lower number of presentations to EDs (and not co-located GP clinics) indicates a lower demand for ED services, presumably as a result of the clinics; and
- The proportion of PCT presentations during co-located GP clinic hours in relation to the total number of presentations (PCT or otherwise) – a relative indication of demand. Thus a lower proportion indicates a lesser demand of these types of services, presumably as a result of the clinics.

➤ **Performance:**

Based on the VEMD data, three key indicators of ED performance were identified that could be compared between hospitals and tracked over time. These performance indicators were used as comparative measures of performance between hospitals:

- Average time to treatment

The number of minutes between arriving at the ED and being attended to by medical staff;

- Treated in target time

Patients who were attended to within specified target waiting times; and

- Left before treatment:

Where the patient left the ED before receiving any treatment.

These data were compared and contrasted for the following groups of hospitals:

- Hospitals with a **co-located GP clinic** (Dandenong Hospital, Frankston Hospital, Northern Hospital and RCH);
- **All Melbourne metropolitan hospitals** to provide a benchmark comparison for demand and performance; and
- One hospital with a **well-located clinic** (Box Hill) to provide a comparison between different models of after hours PCT services.

5.3 Co-located and well-located clinics' impact on demand

The number of PCT presentations during clinic hours was tabulated by hospital and year to determine the impact of co-located and well-located clinics on demand for ED services.

5.3.1 Change in overall demand

Overall, demand for after-hours PCT services has increased over the last five years for all Melbourne metropolitan hospitals.

Demand for PCT services during clinic hours has also increased, but at a lesser rate.

Overall demand for PCT services *after hours*² in Melbourne metropolitan hospitals has increased for the past five years from 210,238 presentations to 238,055, an increase of 13% (Table 2).

	Number of Presentations					
	2001/02	2002/03	2003/04	2004/05	2005/06	(%change) ³
PCT presentations during clinic hours	132,777	140,753	126,798	131,827	140,865	+6%
All PCT presentations after hours	210,238	219,179	214,907	224,339	238,055	+13%

Similarly, demand for PCT services *during clinic opening hours* has also increased from 132,777 presentations to 140,865 (6% increase). It should be noted that a lesser increase in demand was noted for presentations during clinic hours compared with all after hours presentations.

5.3.2 *Impact of clinics: Number of PCT presentations during co-located GP clinic hours*

The introduction of co-located GP clinics was associated with a reduction in demand for the Dandenong Hospital, and to a lesser extent, Northern Hospital.

No clear change in demand over time was apparent for Frankston Hospital.

The re-location of a well-located clinic at Box Hill was associated with a decline in demand for PCT services.

The introduction of co-located GP clinics was associated with a reduction in the number of PCT presentations for the Dandenong Hospital and to a lesser extent, the Northern Hospital. The introduction of a well-located clinic at Box Hill was associated with a decline in PCT presentations. Insufficient data was available for the Frankston Hospital and the RCH.

- For the Dandenong Hospital, the introduction of the co-located GP clinic in 2003 appeared to be associated with a decline of PCT presentations from 7,523 in 2002/03, to 5,107 in 2005/06, a 32% reduction. Overall, a clear declining trend in PCT

² The DHS definition of after hours has been used for this analysis.

³ Percentage change over time is based on the number of presentations in 2005/06 compared with the number of presentations in 2001/02

presentations during clinic hours was observed from 6,730 in 2001/02 to a low of 5,107 in 2005/06 (a decline of 24%).

- PCT presentations fluctuated over the five years for the Frankston hospital, with no clear trend emerging. An overall increase of 10% was observed. (VEMD data was not available for the year that the Frankston Hospital co-located GP clinic was introduced).
- For the Northern Hospital: introduction of the co-located GP clinic in 2005 was associated with a fall in PCT presentations from 12,472 in 2003/04 to 10,980 in 2005/06, a 12% reduction. Overall, PCT presentations fluctuated for Northern over the five years with a peak observed in 2003/04 (the year before the clinic opened).
- Overall, minor fluctuations were observed for the RCH with a slight decline of 4% in demand for PCT services overall (the co-located GP clinic became operational in 2006, thus no time-series comparison was possible).
- The re-location on Box Hill of a well-located clinic in 2005 appeared to be associated with a decline of 8% in PCT presentations from 4,485 in 2003/04, to 4,104 in 2005/06. Overall for the five years, Box Hill Hospital showed a declining trend in the PCT presentations (-15%).

	Number of Presentations					5 Year change	Change Since Clinic Opened
	2001/02	2002/03	2003/04	2004/05	2005/06		
Dandenong (opened '03)	6,730	7,523	6,407	5,703	5,107	-24%	-38%
Frankston (opened '93)	3,202	3,798	3,254	3,084	3,518	+10%	-
Northern (opened '05)	6,535	8,018	12,472	10,445	10,980	+68%	-12%
RCH (Opened '06)	14,097	13,338	13,533	13,446	13,585	-4%	-
Box Hill Hospital (relocated 05)	4,822	4,929	4,485	4,307	4,104	-15%	-8%

	Clinic operational
	Clinic not operational

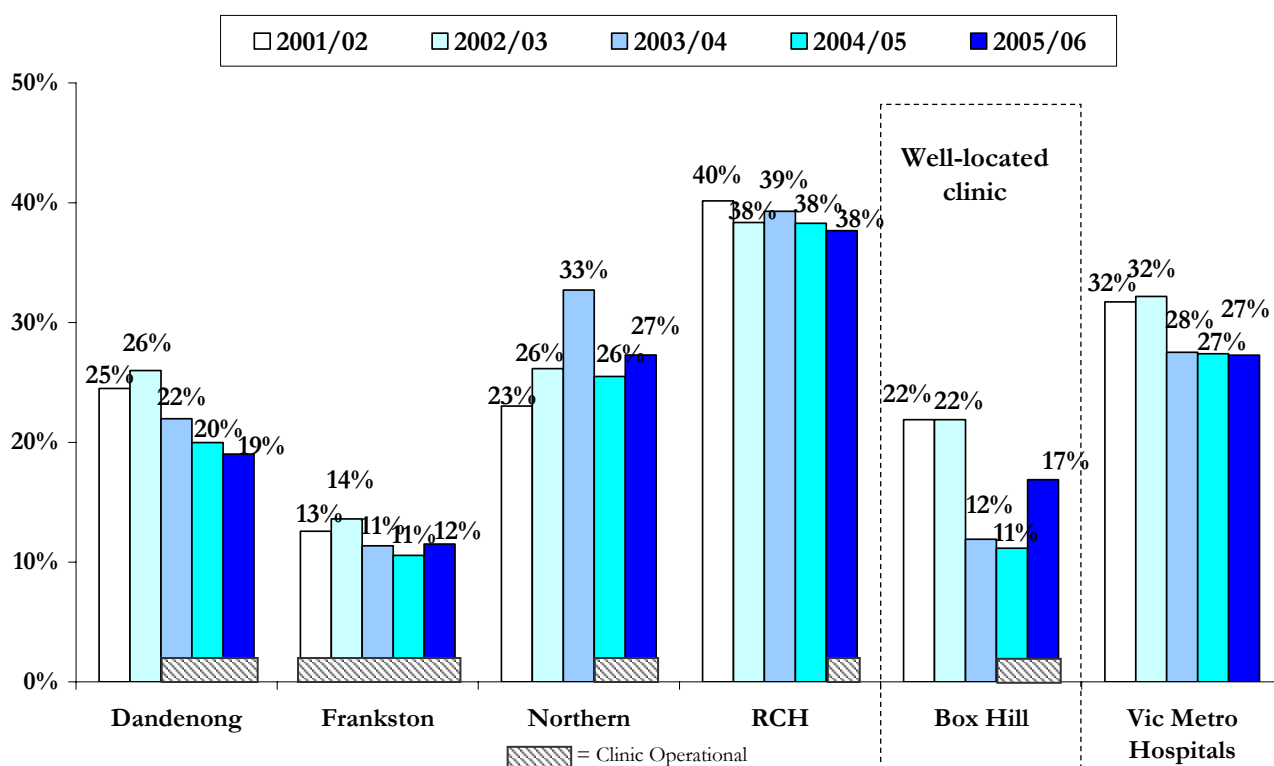
5.3.3 Impact of co-located GP clinics on demand: Proportion of PCT presentations during co-located GP clinic hours

The proportion of PCT presentations during clinic hours in relation to the total number of presentations (PCT or otherwise) was calculated. This proportion gives an indication of *relative* demand for PCT services in EDs (i.e., a lower proportion indicates a lesser demand of these types of services, presumably as a result of the co-located GP clinics).

Overall, the presence of a co-located GP clinic was associated with reduced demand (in terms of the proportion of PCT patients in EDs) for the Frankston, Dandenong and Northern Hospitals.

The presence of a well located clinic in Box Hill also appeared to be associated reduced demand.

Figure 3: Proportion of PCT presentations during co-located GP clinic hours



Base: Presentations during clinic hours						
2001/02:	Dandenong=27,461	Frankston=25,471	Northern=28,388	RCH=35,101	Box Hill=22,030	VIC Metro Hospitals=418,522
2002/03:	Dandenong=28,953	Frankston=27,915	Northern=30,655	RCH=34,770	Box Hill=22,516	VIC Metro Hospitals=437,433
2003/04:	Dandenong=29,159	Frankston=28,644	Northern=38,135	RCH=34,456	Box Hill=37,671	VIC Metro Hospitals=460,835
2004/05:	Dandenong=28,555	Frankston=29,228	Northern=40,958	RCH=35,114	Box Hill=38,640	VIC Metro Hospitals =481,179
2005/06:	Dandenong=26,867	Frankston=30,578	Northern=40,248	RCH=36,067	Box Hill=24,324	VIC Metro Hospitals =516,686

Of all presentations to EDs in Metropolitan Melbourne during clinic hours, one in three (32% to 27%) were PCT presentations (Figure 3). Relative to the metropolitan state figure:

- Frankston showed a far lower proportion of PCT presentations (between 11% and 14%);
- Dandenong showed slightly lower proportions (19% to 26%);
- The Northern Hospitals showed similar proportions (23% to 33%);
- The RCH showed far higher proportions of PCT patients (38% to 40%); and
- Box Hill (where the well-located clinic is situated) showed a far lower proportion of (11% and 22%).

A limited number of trends were observed over time in relation to relative demand for services before and after the introduction of the clinics:

- A reduction in demand was observed for the Dandenong Hospital (falling from 26% prior to the commencement of the clinic in 2003, to 19% in 2005/06);
- A similar reduction was seen for the Northern Hospital from 33% to 27%;
- Insufficient data were available for the Frankston Hospital and the RCH; and
- An indistinct trend was observed for Box Hill, where a well-located clinic was introduced in 2005. Overall, demand for services fell from 22% to 17% over the five years in question. However, this decline did not seem to be directly related to the re-location of the clinic.

5.4 Co-located GP clinics' effect on quality of services

The impact of the co-located GP clinics on quality and timeliness of services in the ED was assessed using the three KPIs discussed in the introduction of this section: average time-to-treatment, treated in target time and left before treatment.

5.4.1 Average time-to-treatment for ED PCT during co-located GP clinic hours

The average time-to-treatment for PCT patients during clinic hours were calculated for each of the five hospitals and for all Melbourne metropolitan hospitals to identify any trends and patterns across the five financial years (2001/02 to 2005/06).

The presence of a co-located GP clinic appeared to be associated with a slight decline in waiting times for the Dandenong Hospital, and for a lesser extent, the Northern Hospital.

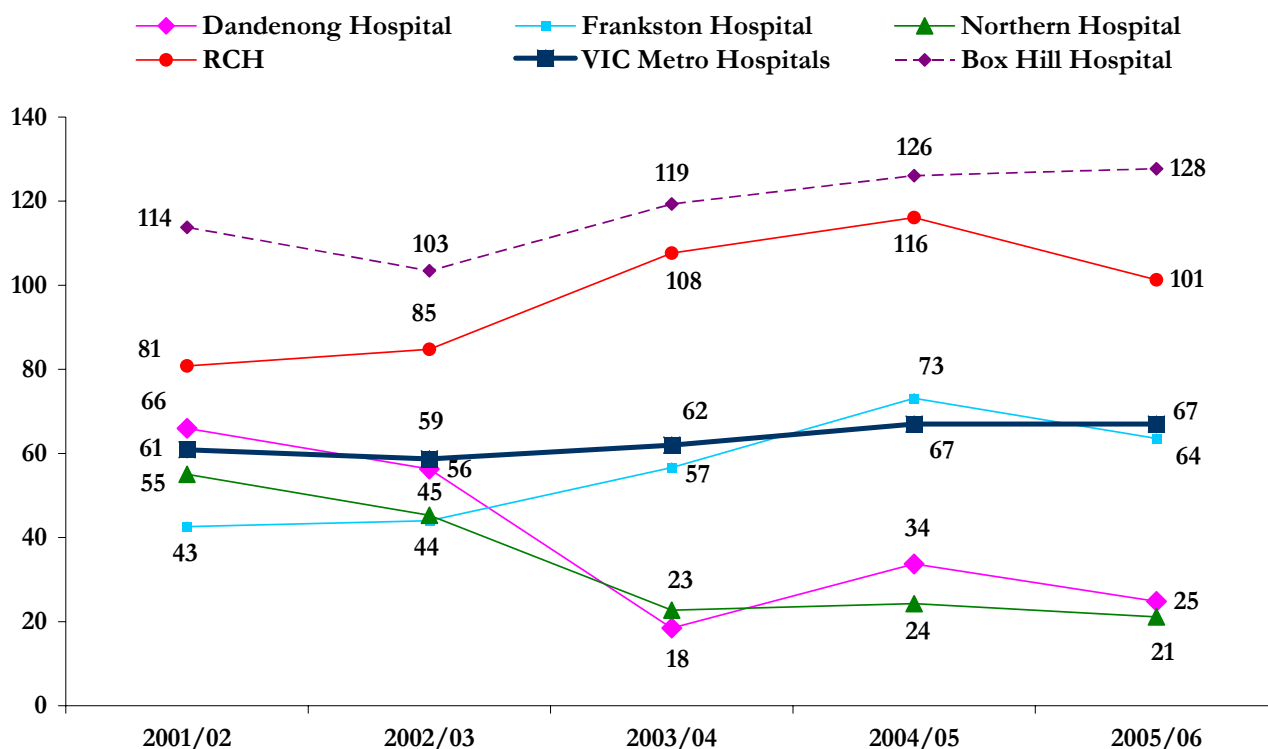
Little impact was seen for all other hospitals, including the well-located clinic at Box Hill.

The introduction of co-located GP clinics was associated with lower average time-to-treatment for PCT patients during clinic hours for the Dandenong and Northern Hospitals (Figure 4). Other hospitals showed no such trend over the five year span, or following the introduction of a co-located GP clinic.

- The co-located GP clinic at the Dandenong Hospital became fully operational in 2003, which may be associated with a decline in average waiting time of 56 minutes in 2002/03 to 25 minutes in 2005/06. Since 2003, average waiting times for Dandenong have been substantially lower than the Melbourne metropolitan average.
- Although the Frankston Hospital was in operation for the entire five-year span, the average waiting time has been increasing consistently from 2001/02 to 2005/06. A slight decline was observed in 2005/06. The average time-to-treatment at Frankston has been similar to the Melbourne metropolitan averages for the last three years.
- The co-located GP clinic at the Northern Hospital became fully operational in 2005 – between 2004/05 and 2005/06 a minor decrease in average waiting time was observed from 24 minutes to 21 minutes (following on from an already declining trend). The averages have declined substantially from 2003/04 and were well below the average time-to-treatment for all Melbourne metropolitan hospitals.
- At the RCH, the average time-to-treatment was 101 minutes in 2005/06, which was substantially higher than the Melbourne metropolitan average. The RCH co-located GP clinic became fully operational in 2005/06 thus no time-series comparisons can be made.

The highest average time-to-treatment was observed for the Box Hill Hospital. The well-located clinic at Box Hill was relocated in 2005. However, little impact was seen in terms of waiting time. Despite the slight decline in the first two years, the average time has been increasing gradually from 103 minutes in 2002/03 to 128 minutes in 2005/06.

Figure 4: ED PCT patients' average time to treatment



Base: After hours PCT patients during clinic hours						
2001/02:	Dandenong=6,730	Frankston=3,202	Northern=6,535	RCH=14,097	Box Hill=4,822	VIC Metro Hospitals=132,777
2002/03:	Dandenong=7,523	Frankston=3,798	Northern=8,018	RCH=13,338	Box Hill=4,929	VIC Metro Hospitals=140,753
2003/04:	Dandenong=6,407	Frankston=3,254	Northern=12,472	RCH=13,533	Box Hill=4,485	VIC Metro Hospitals=126,798
2004/05:	Dandenong=5,703	Frankston=3,084	Northern=10,445	RCH=13,446	Box Hill=4,307	VIC Metro Hospital=131,827
2005/06:	Dandenong=5,107	Frankston=3,518	Northern=10,980	RCH=13,585	Box Hill=4,104	VIC Metro Hospital=140,865

5.4.2 Treated in target time for ED PCT during co-located GP clinic hours

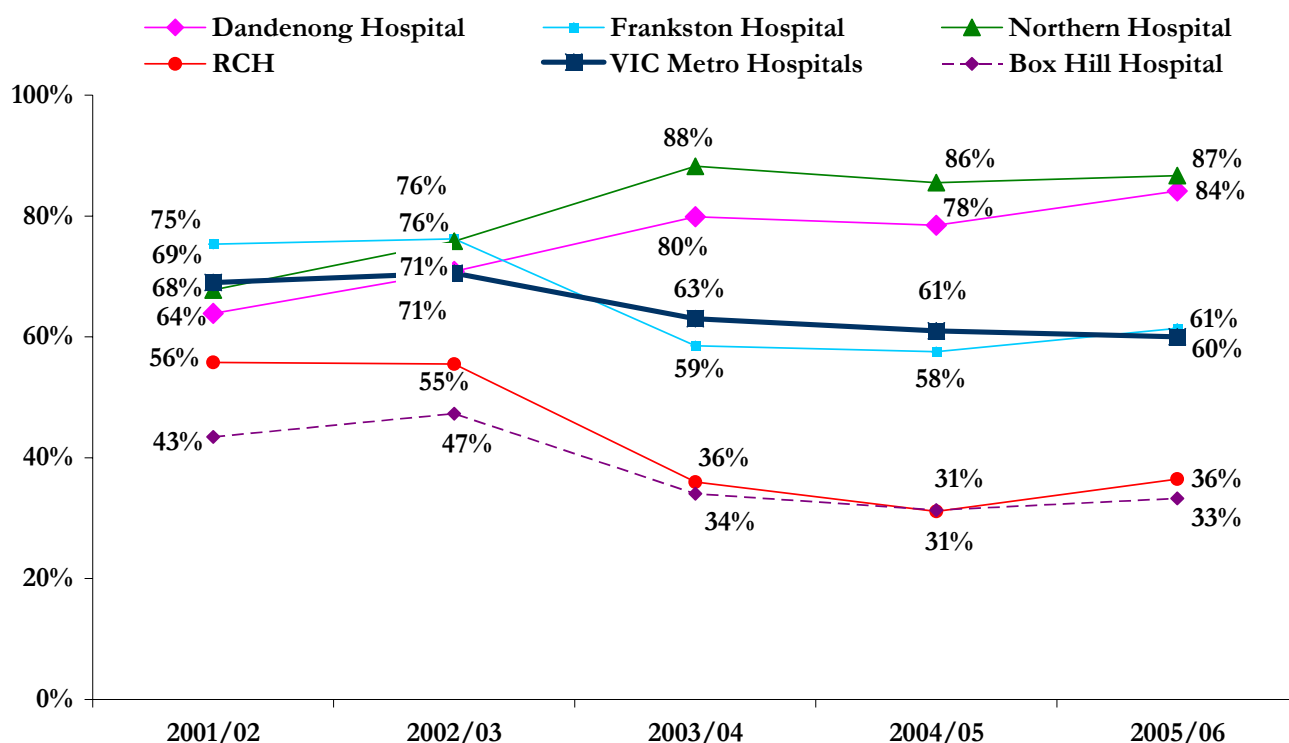
The yearly proportions of PCT patients during co-located GP clinic hours that were treated in target time were reviewed to identify any trends and patterns across the five financial years (2001/02 to 2005/06).

The proportion of PCT patients treated in target time increased in 2003/04 for Dandenong and Northern Hospitals. This occurred when Fast Track was introduced and at the same time as the co-located GP clinic at Dandenong.

The introduction of clinics at other hospitals appeared not to be related to an increase in performance in this regard.

The presence of a co-located GP clinic appeared to have a positive effect on the proportion of PCT patients treated in target time during clinic opening hours for the Dandenong Hospital (Figure 5).

Figure 5: Treated in target time for ED PCT during clinic hours



Base: After hours PCT patients during clinic hours						
Yr2001/02:	Dandenong=6,730	Frankston=3,202	Northern=6,535	RCH=14,097	Box Hill=4,822	VIC Metro Hospitals=132,777
Yr2002/03:	Dandenong=7,523	Frankston=3,798	Northern=8,018	RCH=13,338	Box Hill=4,929	VIC Metro Hospitals=140,753
Yr 2003/04:	Dandenong=6,407	Frankston=3,254	Northern=12,472	RCH=13,533	Box Hill=4,485	VIC Metro Hospitals=126,798
Yr 2004/05:	Dandenong=5,703	Frankston=3,084	Northern=10,445	RCH=13,446	Box Hill=4,307	VIC Metro Hospital=131,827
Yr 2005/06:	Dandenong=5,107	Frankston=3,518	Northern=10,980	RCH=13,585	Box Hill=4,104	VIC Metro Hospital=14,865

Some improvements were seen for the Northern Hospital, though these largely occurred before the co-located GP clinic was established (the improvement of treated in target time occurred at the time Fast Track was introduced.).

- The co-located GP clinic at the Dandenong Hospital became fully operational in 2003; a slight increase in the proportion of patients treated in target time was observed following this introduction. Generally, the Dandenong Hospital's proportions were similar to the Melbourne metropolitan figures in 2001/02 and 2002/03 and have increased substantially in 2003/04. The proportion of PCT patients treated within target time has increased further to 84% in 2005/06.

- The co-located GP clinic at the Frankston Hospital was operational for all of the five year period. Following a marked decline between 2002/03 and 2003/04, the proportion treated in target time remained relatively constant. For the five year period, the Frankston Hospital reported that between 59% and 75% of PCT patients were treated in target time, a proportion similar to the Melbourne metropolitan figure.
- The co-located GP clinic at the Northern became fully operational in 2005, however, no substantial effect on treatment in target time was observed following this event. The Northern Hospital consistently reported the highest proportion of PCT patients treated in target time (87% in 2005/06). The Northern Hospital's proportion was similar to the Melbourne metropolitan proportion in 2001/02 and has been increasing ever since. A substantial increment in the proportion of patients treated in target time was observed in 2003/04.
- The proportion of PCT patients treated within target time at the RCH was consistently lower than the Melbourne metropolitan figure for the five year period. The co-located GP clinic at the RCH did not become fully operational until 2006 and thus no time series comparisons have been made.
- The well-located clinic was relocated to Box Hill in 2005; however this relocation appeared to have little effect on the proportion of patients treated in target time. The Box Hill Hospital reported the lowest proportion of PCT patients treated within target time (33% in 2005/06); substantially lower than the Melbourne metropolitan figure.

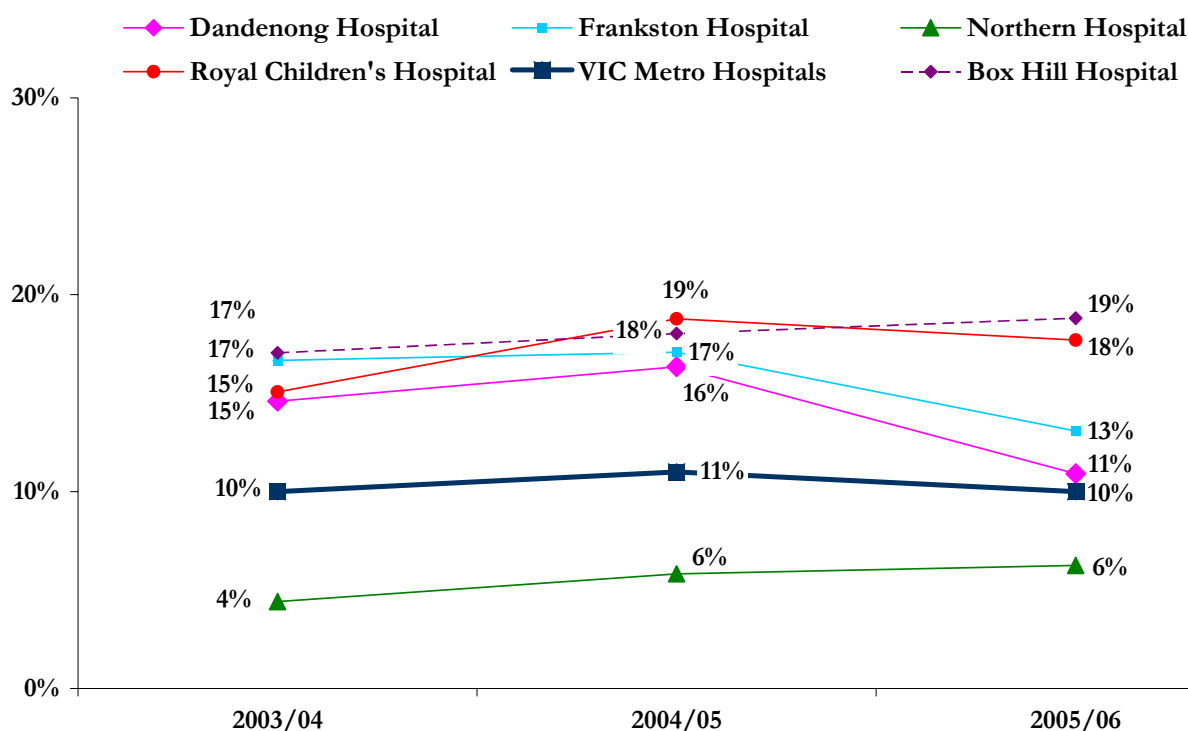
5.5 Left before treatment during co-located GP clinic opening hours

The yearly proportions of PCT patients during clinic hours that left before treatment were calculated to identify any trends and patterns from 2003/04 to 2005/06. No data was available for the preceding years as this variable was not recorded in the VEMD at this time.

A slight reduction in the proportion of PCT patients leaving before treatment was observed for the Dandenong and Frankston Hospitals between 2003/04 and 2005/06. No substantial change was observed for the other hospitals

Across the three financial years, the proportion of PCT patients who left before treatment time was 10% to 11% for all Victorian metropolitan hospitals (Figure 6).

Figure 6: Left before Treatment for ED PCT during clinic hours



Base: After hours PCT patients during clinic hours						
Yr 2003/04:	Dandenong=6,407	Frankston=3,254	Northern=12,472	RCH=13,533	Box Hill=4,485	VIC Metro Hospitals=126,798
Yr 2004/05:	Dandenong=5,703	Frankston=3,084	Northern=10,445	RCH=13,446	Box Hill=4,307	VIC Metro Hospital=131,827
Yr 2005/06:	Dandenong=5,107	Frankston=3,518	Northern=10,980	RCH=13,585	Box Hill=4,104	VIC Metro Hospital=140,865

The Northern Hospital recorded the lowest proportion; the RCH and Box Hill Hospital recorded the highest proportion. A notable decline was in the proportion of PCT patients leaving before treatment for the Dandenong Hospital and the Frankston Hospital, particularly between 2004/05 and 2005/06.

- The co-located GP clinic at the Dandenong Hospital was fully operational since 2003, and a notable decline in the proportion of PCT patients who left before treatment was observed from 16% to 11% between 2004/05 and 2005/06. The proportion reported at Dandenong was similar to the Melbourne metropolitan figure.
- Despite the presence of a co-located GP clinic, the Frankston Hospital reported a relatively high proportion of PCT patients who left before treatment (13% in 2005/06). However, like the Dandenong Hospital, this figure was lower than that reported in 2004/05 (17%). The reduction at Frankston may be associated with the funding of a nurse under RTC Medicare.

- The Northern Hospital reported the lowest proportion of PCT patients who left before treatment (6% in 2005/06). The proportion of PCT patients leaving before treatment was relatively stable over the three years with no effect apparent following the introduction of the co-located GP clinic in 2005.
- The proportion of PCT patients who left without treatment in the RCH was substantially higher (18% in 2005/06) than the Melbourne metropolitan figure. This proportion was similar to that reported in 2004/05 (19%), and higher than that reported in 2003/04 (15%). No time series comparisons are possible due to the recent opening of the co-located GP clinic.
- Despite the presence of a well-located clinic nearby, the Box Hill Hospital reported the highest proportion of PCT patients who left without treatment (19% in 2005/06) and has been increasing gradually since 2003/04.

6. Service delivery models and organisation structures

The business model and governance of the clinics differed in each of the four co-located GP clinics (Table 4). These range from cost units of the hospital, to a co-operative of local GPs, an independent company jointly owned by the hospital and local Division and a private practice (“*a co-operative of one*”).

6.1 Governance arrangements

The governance structures varied for each of the four co-located GP clinics.

Subsection 19(2) of the Health Insurance Act 1973(Cth) establishes constraints on the payment of Medicare benefits for services provided in public hospital settings:

“A Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with the Commonwealth; a State, a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.”

Stakeholders were aware of this restriction when establishing the co-located GP clinics:

“When the clinic was initially established we were very conscious of the need for it to be a separate entity with regards to the boundaries between the public hospital and Medicare.” (Clinic Management)

At Dandenong, the co-located GP clinic is owned by Southern Health. In Frankston the co-located GP clinic is a completely separate corporate entity (Table 4). At Northern the clinic is operated by an independent Company Limited by Guarantee, which is governed by a Board with directors nominated by the hospital and the Northern Division, while at the RCH, the co-located GP clinic is owned and operated by a single general practice, the Keilor Road Medical Centre.

A detailed analysis of governance issues raised in the consultations is provided as
Appendix 1.

	<i>Dandenong</i>	<i>Frankston</i>	<i>Northern</i>	<i>RCH</i>
Clinic first opened	November 2003	Established 1986 Co-located since 1993	May 2005	August 2006
Ownership	Owned by Southern Health, operated by the Continuing Care Unit (previously Primary Care Unit) Private billing practice run as a cost unit within Southern Health	Private billing practice (Medicentre) Managed by a co-operative of local GPs Independent Board of Director drawn from local GPs	Independent Company Limited by Guarantee Board includes nominees from Northern Health and Northern Division ED Director has administrative responsibility	Private practice Owned and managed by sole Director of Keilor Road Medical Centre (KRMC)
Clinical governance (Who is responsible for clinical quality)	Southern Health	Medicentre	Currently lies with ED director, though clinical governance is unclear from the point of view of both the Hospital and the clinic	KRMC
Operational management (Who is responsible for hiring/firing/paying GPs)	Southern Health	Medicentre	ED Director, Northern Health as Practice Manager	KRMC
Executive management (Formal meetings arrangements etc)	Clinic doctors meeting and clinic staff meeting held every 2 months No formal executive arrangement between clinic and ED	Meetings quarterly between clinic Practice Manager, Advisory Committee member and a representative from Peninsula Health Executive	Board meets monthly	Formal quarterly meetings (with ED director; Hospital staff & Practice Director) Informal weekly meetings between ED director and Practice Director
Operational relationship (between clinic and ED staff)	Minimal (ED has no clinical input into the clinic)	Minimal: (Clinic GPs may ask EDs to consult on x-rays etc)	Minimal: (GPs largely unknown to ED but nursing and admin staff are Northern employees)	Encouraged: Triage nurses have a relationship with clinic admin staff GPs communicate regularly with triage nurses

6.2 Funding of co-located GP clinics

Co-located GP clinics are funded through a mix of Medicare rebates, public subsidy, patient fees and co-payments. Each co-located GP clinic has a different approach to patient billing ranging from bulk billing only to full fee payment for all but children (Table 5).

This section identifies stakeholder perceptions of financial viability, funding sources and fee policy identified in the consultation with EDs, co-located and well located clinics. Analysis of the financial viability of the clinics is detailed in Section 7.

	<i>Dandenong</i>	<i>Frankston</i>	<i>Northern</i>	<i>RCH</i>
Patient billing	Co-payment (max of \$15 out of pocket) Health Care card holders and pensioners are bulk billed 70-80% bulk billed	Fee for service \$65 (maximum \$22.50 out of pocket) \$55 before 8 pm Mon – Fri and 1 pm Sat Bulk billing for children under 16 and for procedures)	Bulk bill only (No out of pocket cost to the patient)	Bulk bill only (No out of pocket cost to patient)
RTC Funding	RTC funding until 2009 \$41,000 for 05/06	\$500,000 since 2005	\$200,000 for 06/07	Application unsuccessful
Direct DHS funding	No	No	\$260,000 for 05/06	\$250,000 for 06/07
Indirect funding (through Health Service)	Southern Health subsidies of approx \$10,000 per month	Non-commercial rent for shared space (1/3 commercial rate)	ED Director time	GP Director time for management and establishment is not paid

6.3 Purpose of establishing co-located GP clinics

Co-located GP clinics were established to provide after hours medical care to patients presenting to EDs where there were insufficient general practice services to meet demand and where ED services were in high demand. Each was developed in the context of a constellation of local needs.

Review of the funding applications identified three main purposes for establishment of general practice clinics to be co-located in EDs. These are to:

- Reduce demand on ED services by treating patients that are more appropriate for a general practice than an ED;
- Support local GPs who are unable (or unwilling) to provide after hours care; and
- Ensure that local communities, particularly those that are disadvantaged, have access to quality after hours primary medical care where those services are not accessible.

A lack of clarity regarding the purpose for the establishment of the co-located GP clinics was identified in the consultation. Not all stakeholders were supportive with some ED staff considering that funds could be spent more effectively within the ED. Others saw the co-located GP clinic as an opportunity for utilising an additional funding source to help meet the demand for after hours care. GPs and Divisions emphasised the support for under resourced general practices to provide after hours care. Local GPs, through Divisions, supported the co-located GP clinics but only insofar as they did not compete with the local practices.

Funding for co-located GP clinics from DHS has been sought, and provided, on the basis that co-located GP clinics would relieve demand pressure for emergency care in public hospitals. The appropriateness of PCT patients being treated by GPs fits with the broader Victorian Government policy of providing quality and accessible health care, as well as the focus of the *Better Faster Emergency Care* policy of exploring new models of care.

Each of the co-located GP clinics was established to meet specific local needs:

Dandenong co-located GP clinic was established by Southern Health in late 2003. Southern Health was experiencing increased demand on its EDs, with PCT presentations reported to constitute over 50% of all emergency presentations. The co-located GP clinic was developed as one of a number of initiatives to reduce demand pressures on emergency services at Southern Health hospitals. As an outer metropolitan area of lower socioeconomic status, with a high migrant and refugee population Dandenong was experiencing reduced access to general practices. The co-located GP clinic aimed to provide improved access to AHPMC services and offer an alternative to the ED (Southern Health, 2003).

Frankston was initially established in 1986 by local GPs in the Mornington area to provide quality after hours general practice services to the local community in the face of competition from a super clinic providing after hours services. In 1993 Frankston Hospital invited the clinic to co-locate.

Northern Health and the Northern Division first jointly applied for Commonwealth funding to establish a co-located GP clinic at The Northern Hospital in 2001. This initial application was unsuccessful. Northern Health was later identified in the Victorian Government's proposal to DoHA as being one of four health services suitable for the initial round of State and Commonwealth cost-shared co-located GP clinic funding. Funds were provided by DHS and the co-located GP clinic was established in May 2005. Northern was an area of rapid population growth, with high numbers of new migrants, low socio economic status and a dearth of general practices. Local general practices were struggling to meet the in hours demand and were not offering after hours services. Local GPs were concerned about the adequacy of the locum service. The ED was being heavily utilised, particularly by category 4 and 5 patients.

The **RCH** co-located GP clinic was specifically developed to reduce demand for the RCH ED services. The RCH is unique as a hospital because of its specialist paediatric focus. The catchment area is broader than the immediate community. Parents drive past more conveniently located hospitals to get the specialist expertise for their children provided by the RCH. Whilst RCH has a local catchment area (covering several Divisions), the hospital draws patients from all over Melbourne.

The establishment of the co-located GP clinic was driven by the ED “to address the increase in primary care-type demand and improve utilisation of ED, especially after hours” (Royal Children’s Hospital, 2005). The RCH considered that a significant proportion of patients attending the ED could be more appropriately treated by a GP. The co-located GP clinic first opened in August 2006.

6.3.1 Stakeholder perceptions of the purpose for establishing the clinic

The consultation found that stakeholders did not have a clear understanding of the purpose for which the co-located GP clinics were established.

Generally there was a view that the co-located GP clinics were primarily supporting the ED by relieving their patient load and ensuring patients best served by a GP response received it. The co-located GP clinics were generally seen to be responding to a clear, identified need in the community for after hours general practice services.

However, some ED stakeholders were unconvinced of the value of funding this model of care, considering that the resources could be better spent by increasing the funding to the ED where initiatives such as Fast Track and enhanced triage were able to improve patient outcomes while maintaining the clinical control of the ED.

“We would <have preferred> the GP clinic to be within the ED when it was first set up so that we would have a say in the selection of the staff. The staff would be responsible to the ED and they would be supervised ... So that the skills of those people working in that environment would continuously be monitored and upgraded if needed and they could be involved in the Department teaching just as all our other staff in the Department are involved in regular training and skills maintenance. And also we could rotate them through other areas so they have exposure to other areas.” (ED Director)

Another concern expressed by some ED stakeholders was the risk of attracting more PCT patients who may use the ED instead of the co-located GP clinic rather than reducing the number of PCT presentations in the ED.

Co-located GP clinics are complementary to Fast Track. One ED director described Fast Track as being focused on surgical procedures, with co-located GP clinics more suitable for medical type presentations. The consultation identified that there is room for improvement in the development and application of clinical guidelines for identification and appropriate redirection of PCT patients to co-located GP clinics. The current definition of PCT patients is post hoc and not clinically informed.

Fast Track is an approach to delivering emergency care that is grounded in operations research theory which shows that waiting time in a system utilising one queue can be reduced by attending to those with the shortest time requirements.

Fast Track is embedded in the normal operation of the ED. It applies to patients who have limited care/clinical management requirements and who are likely to be discharged after a brief amount of care from ED staff. These patients are ambulatory, non-complex, and with the potential to have their emergency care initiated using clinical treatment protocols by the clinical team. Staffed by a senior emergency physician and an experienced nurse (for example a nurse practitioner), it allows for nurse-initiated management of low acuity patients who meet well-defined criteria.

6.3.2 Relationships with Divisions and local GPs

Support from local GPs was identified by all stakeholders as a key factor in the success of the co-located GP clinics. Divisions provide a vehicle for GP engagement. Divisions were actively involved in the establishment of some of the co-located GP clinics and continue to have active involvement in the ongoing operation of the clinic, supporting recruitment, participating in the Board (in one instance) and facilitating communication between local GPs and the co-located GP clinics. Divisions were perceived by some stakeholders (from both EDs and co-located GP clinics) as being responsible for providing professional development activities tailored to GPs working in the co-located GP clinics.

In the case of Frankston (established before Divisions were introduced), the establishment of the clinic was entirely driven by local GPs who wanted to ensure the local community had access to quality after hours service in the context of a 24 hours super clinic established in competition with local practices.

For the more recently established co-located GP clinics, funding submissions (presented to both DHS and the Commonwealth) emphasised that the purpose of the co-located GP clinics was to provide a service not available to the community.

Nevertheless, local GPs were concerned about the impact of co-located GP clinics on their existing practices. When the co-located GP clinic was being established at the RCH, an agreement was reached between the RCH, local Divisions and DHS in which it was agreed that the bulk-billed co-located practice should:

- Not compete with existing practices;
- Encourage patients to return to their regular GP; and
- Effectively communicate with the patient's local GP.

It was also agreed that patients were to be triaged from the ED and given a *choice* of attending the co-located GP clinic or the ED.

Support from local GPs was identified by all stakeholders as a key factor in the success of the co-located GP clinics. One of the main functions of Divisions is to assist general practice integrate with acute hospitals.

6.4 Workforce

6.4.1 Nature of GP work in co-located GP clinics

The establishment requirements of not competing with local practices restrict the type of practice for the co-located GP clinics. The characteristics of the work were described by stakeholders as:

“Not general practice but emergency care” (Clinic GP)

“No continuity of care” (Clinic GP)

“Nearly every patient is a first patient” (Clinic GP)

Two of the co-located GP clinics reported approximately 30% of the patients were repeat visits, where the patient had attended to the clinic previously but not necessarily for the same conditions. However, the nature of the clinic consultation was focused on treating the patient and referring that patient back to their usual GP (or to a local GP if they did not have a regular GP). As such the role of the co-located GP differed from standard general practice and to some degree, was less professionally satisfying for the GP.

GPs were employed by the co-located GP clinics on a contract basis (Table 6). As such they were responsible for their own medical indemnity insurance, superannuation and holiday pay. The impact of this relationship on workplace culture is discussed in more detail below (Section 6).

6.4.2 Organisation of the co-located practice

The staffing structure for most of the co-located GP clinics comprises one or more GPs supported by a receptionist and a practice nurse (Divisions 1 Registered Nurse). A Practice Manager responsible for rosters, general administration, and collection of fees was also important. Involvement of a GP as practice principal taking on an executive role has been on a voluntary basis where it exists.

In one of the co-located GP clinics a practice nurse is made available from the ED on an as needs basis. In another the practice nurse has been made possible due to RTC funding.

	<i>Dandenong</i>	<i>Frankston</i>	<i>Northern</i>	<i>RCH</i>
Number of GPs available	11 (recruitment of 2 more underway)	30	8	11
Involvement of local GPs	Majority of GPs employed are from local area (only 2 GPs are from outside of the Dandenong area)	Clinic staffed by roster of local GPs from the Frankston areas.	GPs are not necessarily local. One GP from other side of the city, others are about 30 minutes drive	Not necessarily local GPs
Employment status of medical staff	Independent contractors GPs are external service providers contracted to Southern Health	Local GPs work on an associate model where a percentage is paid to the clinic to cover operating costs and the remainder is retained by each GP	Independent contractors GPs are external contractors to the independent company that runs the clinic	External service providers contracted to KRMC Option of salaried or a % of the consultation fee
Employment status of Practice Manager	Practice Nurse Manager employed by Southern Health	Practice Manager is employed by Medicentre	Currently the ED Director of Northern Hospital is also the Practice Manager	Part-time Practice Manager seconded from RCH and employed by KRMC
Employment status of clinic nurse	Clinic seconds Div 1 RNs employed by Southern Health	RN employed by Medicentre	Clinic seconds RN employed by Northern Health	No nurse at clinic, close relationship with ED ensures that nurses available if needed
Employment arrangements for other clinic staff	Receptionist employed by Southern Health to work in clinic	Administrative support, receptionist and nurse all employed by Medicentre	Receptionist seconded from Northern Health Clerk also seconded from Northern	Receptionist employed by KRMC
Recruitment process for clinic GPs	Approaches to local GPs through Dandenong Division & Southern Health	Word of mouth; via Mornington Peninsular Division	Word-of-mouth; advertise within Northern Division	Word-of-mouth; advertise with Northern and North West Melbourne Divisions

6.5 Operation of the co-located GP clinics

6.5.1 Co-located GP clinic opening hours

The co-located GP clinics are special purpose after hours clinics and the opening hours reflect this. Co-located GP clinics open after 6 pm during weekdays, after 12 midday on Saturday and on Sundays and public holidays (Table 7). That is, the co-located GP clinics have been established to meet the peak demand for after hours care to maximise viability rather than reflect the Medicare definition. The closing times reflect local demand which falls substantially later in the evening (after 10 pm, although one clinic opened until after midnight).

The co-located GP clinics were open for between 45 hours a week (at Northern) and 51 hours a week (at the RCH). Hours increased in weeks which included public holidays.

Table 7: Hours of operation and consulting room.				
	<i>Dandenong</i>	<i>Frankston</i>	<i>Northern</i>	<i>RCH</i>
Hours of operation	<i>Week-days:</i> 6 pm – 11 pm <i>Week-ends:</i> 1 pm – 11 pm (Sat) 1 pm – 11 pm (Sun)	<i>Week-days:</i> 6 pm - 10:30 pm <i>Week-ends:</i> 12 pm - 10:30 pm (Sat) 9 am - 10:30 pm (Sun)	<i>Week-days:</i> 7 pm – 12 pm <i>Week-ends:</i> 2 pm – 10 pm (Sat) 10 am – 10 pm (Sun)	<i>Week-days:</i> 6 pm – 12 midnight (Mon/Wed/Fri) 8 pm – 12 midnight (Tue/Thu) <i>Week-ends:</i> 1 pm-12 m/n (Sat) 10 am – 12m/n (Sun) <i>(Closed over January/February)</i>
Total hours per week	45	46.5	45	51

6.5.2 Patient throughput

Co-located GP clinics originally planned for a throughput of 4 patients per hour to be financially viable. The evaluation of the Commonwealth AHPMC program (Australian Healthcare Associates, 2005) reported that the 12 trial AHPMC programs achieved an average throughput of 3.3 clinic patients per hour (range was 1.1 to 6.2).

The target of 4 patients per hour has not been achieved in the newly established co-located GP clinics (Table 8).

	<i>Dandenong 05/06</i>	<i>Frankston 05/06</i>	<i>Northern 05/06</i>	<i>RCH 06/07*</i>
Number of consulting rooms	3 consulting and 1 treatment/procedure	2 consulting and 1 treatment	4 consulting	3 consulting
Annual total visits	6,500	12,600	4,338 (estimate)	4,584 (annualised from 4 months)
Visits per hour	between 2.6 and 3.4	5 (estimate)	2.5 (estimate)	2

* RCH co-located GP clinic was not in operation during 2005/06

6.5.3 Co-located GP clinic utilisation

The level of utilisation of existing resources is a key determinant of financial viability. There are two estimates of utilisation – actual utilisation of GPs measured by patient throughput and potential utilisation based on estimates of co-located GP clinic capacity.

The potential capacity of the co-located GP clinics has been estimated by multiplying the number of consulting rooms by the opening hours. It is recognised that full utilisation is unlikely to occur because of variable presentation numbers, achievable patient throughput and workforce availability. Co-located GP clinic and ED staff indicated that presentation to both ED and the clinic varied unpredictably and were determined by both redirections from the ED and self referral or “walk in” presentations to the co-located GP clinics. Observation by CR&C during the patient interviews confirmed unpredicted quiet periods with few presentations of PCT patients.

The current co-located GP clinics are underutilised. Using a low throughput target of 4 patients per hour, the estimated utilisation rate was between 12% and 43% of clinic capacity (Table 9).

	<i>Dandenong 05/06</i>	<i>Frankston 05/06</i>	<i>Northern 05/06</i>	<i>RCH 06/07</i>
Potential GP hours (A)	135	139.5	180	153
Patients per hour(B)	4	4	4	4
Annual capacity (A * B * 52)	28,080	29,016	37,440	31,824
Actual throughput	6,500	12,600	4,338	4,584
Utilisation	23%	43%	12%	14%

(A) Estimated from number of rooms * clinic hours (Table 7)

(B) Identified as target throughput by newly established clinics.

There is room for increasing co-located GP clinic capacity within the current physical infrastructure. If there was sufficient demand and there were sufficient GPs prepared to work in the clinics.

6.6 Location and signage

Prominent positioning of the co-located GP clinic is a key factor that influences general community awareness of the clinics and the immediate awareness by patients who attend the ED for emergency care. RTC funding requires direct “walk in” access to the clinic by patients.

Signage is important to enable patients to access the co-located GP clinics directly. Consultations with co-located GP clinic staff and management consistently reported that current signage did not encourage direct access to the clinic. This was deliberate policy at the RCH which only received patients redirected from the ED.

All four clinics were located in close proximity to the hospital ED, though exact distance varied (Table 10)

	<i>Dandenong</i>	<i>Frankston</i>	<i>Northern</i>	<i>RCH</i>
Location	15 meters across from ED ambulance bay	In main hospital building; approx 30 meters from ED; access through corridors; not directly visible from outside	Directly adjacent to ED entrance	In main hospital building; approx 5 meters “around the corner” from ED; not directly visible from outside
Signage	At entrance to hospital but not within the ED Second illuminated signage in front of clinic	No signage advising ED patients of the clinic	No signage in ED. Outside signage at entrance to ED and clinic.	No signage in ED External signage and signage throughout hospital.

Prominent positioning of the co-located GP clinic is a key factor that influences general community awareness of the clinics and the immediate awareness by patients who attend the ED for emergency care.

6.7 Patient access

Patients access to the co-located GP clinics was either via direct “walk in” or through redirection from the ED. None of the four co-located GP clinics booked appointments for patients (Table 11).

The way in which patients were redirected by the ED had a direct impact on patient throughput and co-located GP clinic utilisation. One of the most important factors influencing the success of co-located GP clinics was the redirection of patients from the ED.

	<i>Dandenong</i>	<i>Frankston</i>	<i>Northern</i>	<i>RCH</i>
Direct access (walk in) / ED redirection	Both ED redirection and walk in (high percentage of direct walk in)	Both ED redirection and walk in (high direct walk in and high referrals by local general practices)	Both ED redirection and walk in (low direct walk in)	Redirection from ED only
% Repeat Visits	30-40% (from Jan 07 to April 07)	Approximately 38% (clinic estimate for 2006)	Unknown – estimated to be minimal	Unknown – estimated to be minimal
% redirected from ED	Averages between 35% - 40% (always under 50%)	Approximately 20% (clinic estimate)	Approximately 80-90% (ED estimate) (lower on week-ends clinic GP estimate)	100%
Mechanism for recording clinic redirection in ED	Triage staff <i>asked</i> to enter names of patients redirected to clinic into ED system (highly dependent on individual nurses and ED workload)	None	None	Patient recorded as ‘discharged to GP clinic’ on HAS
ED triage notes transferred with patient to clinic	No, co-located GP clinic staff have access to ED system to monitor ED status	No	No	No
ED uses Fast Track	Yes	Yes; ED uses ‘green team streamline services’. Totally independent of the co-located GP clinic process, not seen to compete with the clinic	Yes; Fast Track complements co-located redirection – does not compete with the clinic	Fast Track operates; only a small overlap of time with GP clinic, not seen to compete with clinic
Referral by co-located GP clinic to local GPs for follow up	Yes	Yes	Yes	Yes

The consultations identified a number of underlying factors that affect consistency of patient presentation to the co-located GP clinics:

- Clearly defined redirection guidelines;
- Relationships and communication channels between the ED and the co-located GP clinic;
- Perceptions of the confidence and capabilities of clinic GPs;
- The nature of the ED patient mix;
- Payment issues (where the co-located GP clinic charged a fee or co-payment); and
- Other models of care utilised by the ED.

Communication and relationships between the EDs and co-located GP clinics were seen by stakeholders as the main factors influencing the management of redirections, as was the need for clear definitions of the type of patients that can be redirected to clinics.

One of the most important factors influencing the success of co-located GP clinics was the redirection of patients from the ED.

6.7.1 Access to the co-located GP clinic

Direct access to the co-located GP clinic influenced patient throughput. With the clinics relying on “walk ins” and redirection from the ED, the visual presence of the co-located GP clinic was considered by the clinic staff to be a critical factor affecting throughput.

Barriers:

DHS, EDs and Divisions are concerned that walk-in services compete with local GP practices and potentially encourage a new client-base (patients using the co-located for normal general practice needs). A balance needs to be created between conflicting objectives.

“The Divisions didn’t want the after hours clinic to be marketing directly to patients and did not want it to effect local GPs. We have had to rethink this now we have Round The Clock Commonwealth funding which requires providing external access.” (Clinic Management)

“Signage needs to direct clients to the clinic. But also need to manage the ED and the clinic...we don’t want to dump patients on the clinic...we need to manage demand.” (ED Director)

Inadequate signage and the location of the clinics were seen as barriers to redirections and clinic utilisation.

“There are signage issues...it is hard to find the clinic so people are just walking straight into the ED.” (ED Director)

Enablers:

The more established co-located GP clinic, Frankston, was receiving the bulk of patients via direct 'walk ins', supported by local redirection practices (Table 11). There was also a high proportion (40%) of repeat visits, although repeat visits for continuing treatment was not encouraged. The more recently established clinics were more reliant on the ED for patient redirection.

6.7.2 Clearly defined redirection guidelines

The consultations found that triage practices were crucial to the success of the newly established co-located GP clinics. Stakeholders consulted referred to the need for triage to have a clear definition of the type of patients eligible for redirection to co-located GP clinics. Stakeholders specifically stated that the PCT definition did not provide a clear enough guideline.

"The PCT definition is too retrospective ... you don't know the stay or length of time of triage until after..." (ED Director)

"What is the defining line for determining patients that are appropriate to send to the clinic? The PCT is not correct." (ED Director)

The PCT definition was seen by stakeholders from both the clinics and the EDs as being limited, subjective and dependent on the relationship between the ED and the clinic. Some ED directors noted that a proportion of Category 4 and 5 patients were not suitable to be treated by a GP, while other ED directors and clinic GPs highlighted that some more urgent patients (Category 3) could be appropriately managed by a GP clinic. Encouraging less conservative triaging practices was suggested as a way to enable more effective relief to the ED, improve waiting times for patients and reduce failure to waits.

Barriers

The lack of clearly defined redirection criteria created a barrier to consistent patient throughput to the co-located GP clinics. Without clear guidelines, ED staff were unsure about which patients to redirect. Poor communication between the ED and the co-located GP clinic added to the uncertainty in identifying appropriate patients for treatment at the co-located GP clinics.

"The categories are helpful but limited. We have conducted an audit of our records to see what type of patients being seen and how they were being managed. We generated a list of 20 types of conditions to put into categories ... these are not being used yet by triage ... but we need to." (Clinic Practice Manager)

"We don't know how the hospital categorises and identifies patients. We don't know if they got it right." (Clinic GP)

Without a strong management structure within the co-located GP clinic and developed communication channels between the ED and co-located GP clinic, patient redirection guidelines were not utilised.

"Specific guidelines have been developed. We have a list of conditions that are suitable for the clinic. But it is at the discretion of the triage nurse whether or not a patient is referred...it comes down to structure, if there is no proper management structure within the clinic you are not getting communication and feedback between the clinic and the ED." (ED Director)

Confusion regarding the range of procedures available at the co-located GP clinics also hindered the redirection process. A perspective put forward by ED staff was that triage could be reluctant to send patients to a co-located GP clinic if the patient required additional diagnostic procedures, such as radiology and pathology. This reluctance was because the patients were likely to be “bounced back” to the ED to have the procedures performed. ED staff were also concerned that patients could be charged for diagnostic services or procedures.

“They can do radiology and pathology in the clinic, but we don’t encourage it. <The costs> with the state/federal boundaries gets messy. It’s too tricky.” (ED Director)

“Here <in the ED> you get everything done. Whereas over there, the x-rays and pathology is rebated but it is not all done in one go – you have to come across and go back and go home to get your drugs. Here <the ED> it is a package given to you.”(ED Director)

Enablers:

Strong relationships between the ED and co-located GP clinic enabled both parties to work together to develop clear redirection guidelines to encourage consistency in patient throughput. The benefits of a strong relationship with the ED to the redirection process were particularly important from the clinic perspective.

“We plan to address those issues ... we will look at <redirection procedures> together ... to put together a booklet for staff ... to show the staff that the hospital supports what <the clinic> does. So that they can be sure if they should be sending patients to us or not.” (Clinic Manager)

“Problem we had at the beginning was that the triage nurses weren’t all that sure about us and were a bit slow to send patients ... no longer an issue ... everybody is on side ... getting to know us, getting to know the GPs, realising that we are GPs with a lot of experience ... confidence builds up ... the triage nurses are now more happy to send people around.” (Clinic Director/Principal)

From the perspective of one ED, confidence in redirections was improved by shared information, with the ED ensuring that the co-located GP clinic had access to the hospital’s clinical guidelines.

6.7.3 Relationships and communication

The relationship between ED staff and GPs working in the co-located GP clinics was repeatedly referred to as having a significant influence on redirection procedures.

Barriers:

Even with clear redirection guidelines, triage nurses have to make a personal assessment about eligible candidates for co-located GP clinics. Stakeholders from co-located GP clinics and hospitals said this judgement was more difficult for the nurse when relationships and communication channels between the ED and the co-located GP clinic were not developed. In some instances co-located GP clinics considered that redirections were based on personal preferences of triage nurses rather than specific clinical guidelines.

“...some <triage nurses> are great ... ‘yep that’s appropriate you can go there’...and you will have constant flow all night and with others that is not the case at all ... it works well if the triage nurse is switched on and can keep it flowing, as is depended on nurse as well <as the GP on duty>” (Clinic GP)

“But really it is dependant to who is on triage...” (Clinic GP)

“Triage nurse is the tap. If they turn the tap off, there is no patients. And they sometimes turn the tap off. Frequently turn the tap off.” (Division)

The absence of relationships with triage nurses was seen by GPs working in the clinic as having the most significant impact on whether or not patients would be redirected for treatment.

“I know some of them <triage staff> because some of the ED nurses come and work in the clinic...it would help <other GPs> if the triage nurses and GPs were really in-sync.”(Clinic GP)

“Referral is pretty variable and depends who is on triage. Some of them are very good. Depends if they know you...if they know you then they know what types of patients you are happy to see.” (Clinic GP)

The lack of a relationship between the two organisations was also a concern for ED staff, some of whom were uncomfortable redirecting patients for treatment to a practitioner unknown to them.

“The GPs are largely unknown to the ED staff. Nobody involved in the admin of the clinic <from the hospital side> works after hours. So we don’t know <the doctors>.” (ED Director)

“Depending who the triage nurse is, some are hostile to the clinic and there is uncertainty...they think they may lose their jobs if the clinic is too successful. So if you get someone <in triage> who is inexperienced, or has loyalty to the ED, they will direct all patients (no matter what level) through the ED. (Division)

Enablers:

Redirections rely on two elements, clear redirection criteria and the discretion of the triage nurses in deciding which patients to redirect. Co-located GP clinics that had developed communication at a management level were able to develop relationships at a ground level to work through redirection issues.

“The triaging is working really well. The protocol is there at one level and at the other level you have the nurses interested in which doctors are on...areas that the doctors are happy working in and areas in which they don’t feel so skilled we can/can’t handle that one... very much a one to one judgement...it is building relationships.” (Clinic Director/Principal)

“When we started we had issues with the triage nurses <sending inappropriate patients>. The clinic met with the ED so we could find out what the GPs could do ... GPs told the nurses we can handle this, you handle this.” (Clinic Director/Principal)

“... the solution <to increased patient throughput> lies not within how we market, but to relationship with the ED because they are our primary market.” (Clinic Management)

Both co-located GP clinic and ED stakeholders stated that ongoing and dynamic communication was important to encourage consistent redirection practices.

“The GPs will call us and let us know that they are not busy. Then we know that we can send more patients around.” (Triage Nurse)

“Need to tell the triage nurse that they were not wrong – but thanks for thinking, it was great but this case is too much for me to handle – not designate a failure – talk to the nurse and explain why it was inappropriate.” (Clinic Director/Principal)

“It helps if you go out and say hello to the triage person, but that doesn’t always happen ... every night there is a different doctor, which is not easy for the nurses.” (Clinic GP)

A perspective put forward by hospital executive management was that relationships developed over a long period of time generated familiarity and consistent redirection practices.

“Because we have been doing it for so long it has become customary practice ... we know that they can help manage our demand and our workload ... don’t want a service sitting there empty and 10 patients in our waiting room” (Hospital Executive Management)

Strong relationships between the ED and the co-located GP clinic enabled both parties to work together to develop clear redirection guidelines to encourage consistency in patient throughput.

6.7.4 Referrals back to the ED

There were two very distinct opinions about ‘referrals back’ or ‘re-referrals’ from the co-located GP clinic to the ED. In some instances referrals back to the ED were seen a negative outcome, as an indicator of ‘failure’ or inadequate skill levels or confidence on the part of the GP.

“We don’t know what is going on over there, if they are just going to send the patients right back here what’s the point?” (Triage Nurse)

“I had that relationship with the triage nurses from working in the ED, it was a lot better. I kept that contact going and got to know the people on the floor a lot betterwould be harder for GPs that wouldn’t have previous contact with emergency people ...” (Clinic GP)

In contrast, others considered referrals back to the ED as a positive contribution to quality assurance and refining the understanding of triage nurses about which conditions were most appropriate for the co-located GP clinic. Some ED and co-located GP clinic stakeholders viewed referrals back as an indication that redirection procedures were working efficiently and providing a learning process for refining redirections for both the triage nurse and the GPs.

“Inappropriate patients have to go back to the ED. It is going to happen, but depends how it is dealt with ... it is better for the ED to keep the patients that need more attention. It’s an education thing.” (Practice Manager)

“If there are none coming back from the GP clinic, then we are not being aggressive enough ... we would be very concerned if we were not getting any referrals back.” (ED Director)

“The clinic works well because sending a patient back to the ED is not seen as a failure ... can ask for help if you <a GP> feel out of your comfort zone” (Clinic Director/Principal)

Confidence in redirections was enhanced by having a system in place to ensure that patients would not lose their place in the ED system if referred to the co-located GP clinic and then referred back to the ED for additional procedures.

6.7.5 Professional Boundaries, capabilities and experience of clinic GPs

Barriers:

In some co-located GP clinics, the professional boundaries between ED staff and clinic GPs led to assumptions about the ability of GPs to handle acute presentations which were not always tested or confirmed. The confidence and capabilities of individual GPs in treating certain types of acute patients added to the reluctance of some ED staff to redirect patients to co-located GP clinics.

“Triage staff need to feel comfortable with the clinic and they need to feel more comfortable with the quality of care the clinic provides.” (ED Director)

“I am coming from a different approach. That is why I am not sure ... what GPs expectations are for a normal GP clinic with auditing, clinical governance and so forth. But one would expect it to be robust ... but I don't know ... I shouldn't impose my expectations on the clinic. But they are an urgent clinic that should be seeing patients with acute conditions and you want them to be well treated.” (ED Director)

“...there are referral criteria obviously...e.g. cat 4s and 5s, but some GPs may be reluctant to see a fracture...” (Clinic GP)

“GPs being particular, I will see this type of patient, I won't see this type of patient” (Clinic Principal/Director)

Professional barriers were more likely to influence the redirection of patients from the ED when communication between the co-located GP clinic and ED was limited.

“They <the GPs> are unsupervised ... most of our staff get extremely well supervised and I am not used to having people who are unsupervised, don't know how they practice, don't know what their qualifications are...”(ED Director)

For some hospital executives and ED directors, perceived varied skills of GPs working in clinics was a concern.

“...confidence of the GPs to see the types of patients that come to an ED. Some <GPs> are comfortable to do sutures some aren't. Some are comfortably with fractures. Some aren't. If there is a particular GP that the ED thinks will refer patients back ... they will not send patients to the clinic.” (Hospital Executive Management)

Enablers:

Building relationships to facilitate communication and understanding helped some clinics to breakdown the professional boundaries between GPs working in the clinic and ED staff.

“We have a deliberate policy of encouraging relationship building ... we get the <clinic> doctors to go around and read the x-ray in the ED and to talk to the paediatricians, and every time we run out of patients it is policy that the GP goes around and asks how are we going, are there any patients?” (Clinic Practice Principal/Director)

6.7.6 Payment options

Patient fees applied by some co-located GP clinics limited the willingness of some ED directors to redirect patients and impacted on overall clinic utilisation. ED staff could be reluctant to redirect patients to a co-located GP clinic when patients would incur an additional cost.

“The problem is that <the clinic> is not totally bulk-billing. So a percentage of the patients are bulk-billed but the others have to pay something towards their costs...that sometimes is a deterrent for our patients who we suggest might go to the clinic, but can't go because they can't afford to pay.”(ED Director)

“When they introduced co-payments the ED copped abuse for offering an option with a cost to patients” (ED Director)

Payment was not a barrier at the co-located GP clinics where all patients were bulk billed.

6.7.7 Other models of care for non-urgent, low acuity patients (e.g. Fast Track)

Barriers:

The Fast Track system, with GPs and senior residents working within the ED, was seen by some as a more effective and quicker way to deal with less urgent patients who present to the ED:

“We have put resources into this <in the ED> and this is turning of quite efficiently. So if we can do this why do we need a clinic? If the ED was empty why would you send them somewhere else?” (ED Director)

Enablers:

Fast Track was not always seen as an alternative, or competition, to co-located GP clinics. The service could be run at times that did not overlap with clinic opening hours, providing an additional service for non-urgent patients presenting to EDs:

“We went through a phase with the Fast Track primary care program with a GP within the ED mainly to look at our category 4 and 5 patients, because they were the patients that stayed for the longest period of time in the ED...we appointed GPs...made sure that the hours didn't clash with the hours that <the clinic> was open ...did help us with our flow, but we had difficulty recruiting GPs” (Hospital Executive Management)

Another ED perspective specifically stated that Fast Track should not be seen as a competitor to co-located GP clinics, as the two models provided different services: fast-track providing surgical and orthopaedic services whilst the co-located GP clinics provide general medical services.

6.7.8 The nature of the ED

Redirection was also governed by the daily operation of the ED. If the ED was not working to capacity patients were less likely to be redirected through to co-located GP clinics. ED stakeholders also noted the fact that if the ED did not have patients of a low urgency or low acuity, they do not have any patients to redirection to a co-located GP clinic.

“If they <the ED> are not working to capacity, patients are whizzed off into the ED. So our <clinic> doctors are doing nothing. On a quiet night, our doctors will only get a trickle, as they all go into the ED.”
(Division).

“<Redirections> depends on who walks through the door. If we have all urgent Cats 3s or 2s, we can’t send any <patients> around.” (Triage nurse)

6.8 Clinic workforce

Workforce issues are important for the viable functioning of the co-located GP clinics. The recruitment of respected GPs to work in the clinics was a key success factor identified by most stakeholders consulted. It was found that clinic work is attractive to certain types of GPs, namely those who were more altruistic, who wish to attract a new patient base, those who enjoy the variability of episodic, acute work compared with the usual chronic cases seen in general practice, as well as to female doctors who wish to work after hours in a safe environment.

The success of a clinic in attracting and retaining high quality GPs hinged on the following factors:

- Appropriate remuneration of the GPs;
- Training; and
- A dedicated Practice Manager who creates a well functioning clinic in which it is enjoyable to work.

6.8.1 Recruitment of GPs

Barriers

The co-located GP clinics are located in outer metropolitan areas with recognised GP workforce shortages. The RCH is an exception. Local practices have difficulty in recruiting sufficient GPs for in-hours care. The co-located GP clinics must recruit GPs for after hours care in a practice which is professionally isolated, operating in time periods that most GPs are not attracted to and where considerable travel time is required.

Recruitment of GPs to the co-located GP clinics at Dandenong, Northern and the RCH has proved difficult. A number of the co-located GP clinics have encountered workforce shortages resulting in clinic closure for short periods contributing to the uncertainty of the ED in redirecting patients to the clinics.

The co-located GP clinics were established to provide special purpose after hours care. The agreement not to compete with local practices means that the work is episodic and different to usual general

practice care. Some GPs have worked in the ED to upgrade their emergency skills. The separate organisational work culture did not enhance learning opportunities to attract GPs.

The consultation found that it was difficult for the co-located GP clinics to attract suitably experienced GPs. This is because after hours work was not seen as desirable and most experienced GPs are already dedicated to their own practice.

“It’s an ongoing problem to recruit doctors, it’s always difficult to encourage doctors to participate in after hours work, so you have to look at ways of not only attracting them but keeping them.” (Practice Manager)

“They always have difficulty recruiting doctors.”(ED Director)

“Recruitment of GPs is a huge issue, when you are relying on VR doctors. This is not just our problem; it is more global than that.” (Clinic Director)

Unfortunately co-located GP clinic work can be attractive to the ‘wrong type’ of GP. For example, those GPs who are out of work can be a disadvantage to the clinic as their commitment and skill levels may be of questionable quality.

“The GPs that are attracted are new GPs, they are of a lower standard and are often from overseas and not trained in the Australian system.” (ED Director)

Enablers

However there are certain types of GPs who can be attracted to working in the co-located GP clinics, particularly those who are altruistic, and those who have an ageing practice base and those who would like to attract new, younger patients.

“We attract altruistic doctors as well as doctors who’s patient base is getting older and they want to keep up their ... skills.” (Practice GP)

Co-located GP clinic work is also attractive to GPs who are interested in seeing a different type of patient as it offers work they may not have access to in regular general practice, more episodic cases and exposure to acute cases and procedures that require less follow-up.

“The clinic environment is professionally rewarding for GPs as they have the opportunity to see a different type of patient base, especially female GPs who would probably mainly see female patients, and this would change in the clinic.” (Practice Manager)

“They are also seeing acute general practice rather than chronic patients, so it can be a good change, and exposes GPs to some of the emergency medical procedures. The GPs have good resources they can draw on in the ED and good computer resources.” (Clinic Doctor)

In addition, the co-located GP clinics provide a safe working environment for female GPs who are available and prepared to work after hours.

“It’s a safe, after hours environment for female GPs.” (Practice Manager)

6.8.2 Retaining staff - appropriate remuneration

Barrier



The consultation found that generally, after hours work was not attractive to many GPs and that remuneration was an issue. However, increasing remuneration for GPs may alienate ED staff who already believe GPs salaries to be unnecessarily higher their own.

“The difficulty with a pay rise is that it puts the clinic GPs out of parity with Doctors in ED, which creates other issues, so we want to look at other incentives.” (Practice Manager)

Enabler

The fee for working the co-located GP clinics needs to be comparative: firstly to what GPs are able to earn within their own practice, and secondly to take into account the additional requirement of working after hours. However, higher pay may also need to be tied to incentive models, as a flat rate of pay does not encourage doctors to service a higher patient ratio.

“The clinic has become busier over last few years but there is no financial incentive for the Doctors to increase their throughput as they are paid a flat hourly rate. So we are looking at some sort of incentive scheme that could help them increase throughput, such as salary packaging, or being inside the organisation so indemnity is covered.” (Practice Manager)

6.8.3 Training

Barrier

There is little training specifically for GPs working in co-located GP clinics and little involvement of GPs in the ED training programs (Table 12).

Enabler

Some stakeholders noted that the role of ongoing professional development, training and mentoring contributed to maintaining and developing good standards, as well as to attracting capable GPs with the right kind of commitment and motivation. There was a view that the ED could be a very useful teaching environment for GP trainees and was underutilised for this purpose.

	<i>Dandenong</i>	<i>Frankston</i>	<i>Northern</i>	<i>RCH</i>
Training & professional development	<p>None at present</p> <p>GP liaison officer has put in a proposal for GPs to participate in ED education and training programs</p> <p>Training to be consistent with Southern Health credentialing program for doctors</p> <p>Practice Manager engaging GPs with Dandenong Hospital General Medicine Meetings/Seminars</p> <p>GPs achieving own CME points with FRACGP annually</p> <p>Other staff members engaging in CPD via SH and Dandenong and Greater South Eastern Divisions</p>	<p>Little or no joint professional development, however both ED and clinic are involved in professional development through the Division</p>	<p>No ED based training planned (Division expected to provide GP mentoring process)</p>	<p>Informal professional development (action learning opportunities.</p> <p>Clinic and ED planning to hold joint training sessions</p> <p>Specific continual professional development initiated for clinic GPs</p> <p>Expectation that GPs from other co-located GP clinics will be invited</p>

Some stakeholders suggested that opportunities could also be provided for further education, either through the Division or the ED, in relation to acute general practice care such as wound care, fractures and plastering. However, such training is not as simple as involving GPs in current education courses and would require a level of tailoring to existing courses.

“We had hoped that GPs would get access to the free ED training sessions.” (Hospital administrator)

“There are issues with teaching GPs, the ED teaching programs are to train emergency specialists and it is difficult to know how to involve GPs in this sort of training.” (ED Director)

“Training is an attractor, it attracts the right sort of GP.” (Clinic GP)

There was also a suggestion that the co-located GP clinics could be used as a short term work placement for trainee GPs, this would increase the awareness of the clinics in GP circles and attract more staff.

“We are looking for students in GP training to come in and participate in an intern program so they are aware of the clinic and can indirectly attract more staff.” (Practice Director)

The RCH is planning a Continuing Professional Development (CPD) program specifically for GPs working in the co-located GP clinic. It is anticipated that GPs from other co-located GP clinics may be invited to attend.

6.8.4 Dedicated Practice Director and Manager

The Practice Director is responsible for reporting to the Board or hospital management and takes responsibility for liaison with the hospital and the ED, clinical governance and human resources (remuneration, recruitment and personnel management). In two cases the Practice Director is a GP. One is the ED Director and the other is a hospital administrator (supported by a GP liaison officer).

The role of Practice Manager supports the Practice Director and is focused on rostering, support for GPs and the practice and co-ordination of IT support. It also includes developing procedures and standards around clinical care, ensuring GPs are vocationally registered and that this is maintained, the application of accreditation standards (even though this is not currently a requirement) and regular meetings to discuss clinical issues. Practice Managers were not full time, some also took on the practice nurse role in the clinic. In one instance the Practice Manager role was undertaken by the ED Director.

Barrier

The consultations found that the relationship between the ED and the clinic was adversely affected by the lack of a dedicated Practice Manager. Not only did it affect the confidence the ED had in clinic staff, but adversely affected the smooth running of the clinic especially in regard to staffing and development of operating procedures.

“A Practice Manager would make the clinic a much more sustainable place.” (ED Director)

“If there is one person running both the ED and the Clinic – all responsibility and lack of control – I don’t get to meet the GPs, rostering is hard, the GPs don’t know who they are responsible to – who do they go to?” (ED Director)

“Running an ED and a clinic is difficult – they are different animals with different standards – so why wouldn’t you have a proper person in charge <of the clinic>?” (ED Director)

In addition the workforce needs of the co-located GP clinics are subject to seasonal fluctuation. For example most clinics see more patients during winter, so there is a need to increase the number of GPs rostered on during the winter months.

“The Clinic can be seen as inefficient, but only because of seasonality, we get many more patients during winter, 3- 4 patients per hour, if we had 2 Drs on during those months we would get better economy of scale.” (Clinic GP)

“The workload is highly variable, in summer the patient load is very light, but in winter we have many more patients, and that can clog up the system. It’s difficult to organise the staff so we have more on at the times we need them.” (Clinic GP)

In one instance, a substantial amount of time had been volunteered by the Practice Principal to establish the clinic, at a substantial opportunity cost to their external practice.

Enabler

A dedicated Practice Manager was able to be responsive to the needs of the GPs working in the co-located GP clinic creating a supporting environment where the GPs felt at home and welcome, an important issue when working in an organisation on a part-time basis. The Practice Manager could also champion the needs of the GPs to ED management and within the hospital system. This was important to attract and retain quality GPs in the practice.

*“Very important to have a dedicated Medical Director and a Practice Manager in charge of the clinic.”
(ED Director)*

“Who is responsible for clinic governance remains unclear. There should be an independent Practice Manager, not the director of ED. The Drs, nurses and clerks all feel the need for a central leader/coordinator who has the interests of the <co-located GP clinic> as main priority.” (Clinic GP)

In addition the issues of seasonality can be more effectively dealt with by a dedicated Practice Manager who is more tuned into this seasonable variability and can plan ahead.

The employment of a GP Director would require a senior GP to be employed for the equivalent of one to two days per week.

A GP Director in the co-located GP clinics was considered to be a key element in enhancing the leadership to strengthen the co-located GP clinics.

6.9 Workplace culture (in the co-located GP clinics and EDs)

The consultation found there were three key cultural factors that contributed to the success or failure of co-located GP clinics, which were:

- The presence of a dedicated Practice Manager;
- The working relationship between ED Director and Clinic Manager; and
- The everyday workplace culture reflected in the level of communication between the ED and co-located GP clinic.

The quality of the relationship between the ED and co-located GP clinic staff was enhanced when a positive and collaborative culture was fostered. Those associated with the co-located GP clinics in particular, highlighted the need for regular interaction with the ED so that GPs felt less isolated. They believed this was facilitated by being encouraged to consult with ED staff about difficult cases and having access to more professional development opportunities.

6.9.1 Practice management

Barriers

A dedicated Practice Manager was seen as crucial to the creation of a positive co-located GP clinic workplace culture. The lack of a dedicated Practice Manager, for example when this role was integrated with that of ED Director, led to a situation in which the workplace culture of the co-located GP clinic was seen to suffer. Where there was no GP focused leadership there was a perception that a lower standard of facilities were provided to GPs. This ranged from procedures and standards around clinical care, to everyday work culture issues including the provision of tea and coffee facilities. The daily working environment in the clinic was not conducive to attracting and retaining staff.

“You need someone to pull it all together, no one works together, no one is there at the same time, just trying to get information to all the staff members is difficult, they come in and work alone at different times, so you really need someone to pull it all together.” (Practice Manager)

Enabler

A dedicated Practice Manager overcomes what was perceived by the co-located GP clinic staff as the “overly bureaucratic ED environment” and could react more quickly to GP’s needs.

“GPs value their autonomy, they know they can get answers from the Practice manager very quickly and we can get things done quickly. Once you are in a hospital environment it takes a lot longer.” (Practice Manager)

A dedicated clinic manager could champion the needs of the co-located GP clinic within the hospital system.

“If we don’t have a Practice Manager, then there is no voice for the clinic. There are all different GPs working who don’t know each other. So we don’t have contact with each other. There are different nurses. The only continuity is there are 2 clerks, it’s very fragmented. Currently the clerks are pulling it all together, maybe they could take more of a Practice Manager role. It’s a cultural thing, they don’t realise the difference between an emergency department and a clinical practice.”(Practice GP)

“The Practice Manager is an extremely important part of the success of the Clinic.” (Practice Director)

“Communication with the ED has been a struggle, we would tell someone in ED and they would go off duty and they would not inform anyone else there and information would get lost. This is where the practice manager is important as they can stick up a notice or in other ways make sure messages get through.” (Practice GP)

6.9.2 Working relationship between ED Director and the co-located GP clinic

Barriers

The relationship between the ED director and the co-located GP clinic had a significant impact on clinic workplace culture. A weak relationship resulted in relatively poor utilisation of the co-located GP clinic and less than optimal outcomes.

“If the senior management in the ED is not supportive of the clinic, are not talking about it, this trickles down to the triage nurse who is the point of identifying clients, and this results in lost opportunities to refer to clinic.” (Practice Manager)

“We had a Doctor in the clinic who had worked in the ED, but this did not really work as a link as the top down relationship was not there as the ED is a top down driven organisation. So we need a champion within the ED.” (Practice Manager)

It was difficult for ED management to establish any sort of relationship with the co-located GP clinic if a Practice Manager was not present, since GPs in the co-located GP clinics worked different shifts, often not overlapping with senior ED staff.

“How do you meet GPs that always work after hours – how do we establish a relationship with them?” (Hospital management)

“I don’t get to meet the GPs ... GPs don’t know who they are responsible to – who do they go to?” (ED Director)

Enablers

Fostering a positive working relationship between the ED Director and the co-located GP clinic Practice Manager was important. This could be achieved by regular meetings and briefings of the ED Director about clinic procedures. It also affected the ability of the co-located GP clinic to attract dedicated GP staff.

“A lot of personal relationships involved in, and knowing how the <ED> system works is crucial and it does allow us the ability to be in ongoing communication with the ED and overcome the cultural difference between the ED and Clinic. (Practice Manager)

“Holding quarterly meetings with the ED manager, as well as ongoing phone calls helps us to work things out.” (Practice Director)

6.9.3 Differences in workplace culture between the ED and co-located GP clinic

There were substantial differences in the views about the professional cultural differences between EDs and the co-located GP clinics.

Barriers

The ED culture was described, primarily by those outside of it, as young, highly skilled in specialist areas, characterised by strong, inward looking intact teams, with status and praise coming informally from success in managing a busy ED. Within the ED there is a sense that ED work is higher status because it deals with life threatening situations. The work environment in EDs is controlled and sits within a bureaucratic structure with more hierarchy and formalisation. GPs on the other hand tend to work more autonomously in a small business type environment and relate to patients on a relationship basis and deal with more chronic conditions. The fact that GPs are dealing with less urgent presentations can translate into a lack of respect for the work of GPs.

Although the ED showed a tight knit and efficient team, it also gave rise to an ‘us and them’ culture, where co-located GP clinic staff were viewed as outsiders.

“In many ways it is a team, mateship culture They are very inward looking. They regard the clinic as ... a temporary nuisance to them. ...” (Division)

In contrast the culture of the co-located GP clinics was seen as much more autonomous and quick moving, and needing to respond to staffing requirements and requests of GPs promptly to keep it running smoothly. Indeed the co-located GP clinic stakeholders could see the hospital system as a hindrance with unnecessary red-tape interfering effective independent professional practice.

“The clinic culture is more to give something a go, see how it works and if it doesn’t work we will adjust it, but in the hospital system there is protocols and delays, and sometimes the delays can be quite horrendous due to their own internal priorities. So that can cause some difficulties. For example getting signage up took four months.” (Practice Manager)

Associated with this, an attitude of superiority towards the co-located GP clinic GPs was demonstrated by the ED staff. There was a perception that GPs were equivalent to junior doctors whose work required supervision and quality control checks.

“They feel they can handle the patients well, if not better than the GPs. You are trying to break down a pretty entrenched culture.” (Division)

“They feel that GPs are not as competent as them in spotting issues.” (Division)

“They think that the clinic work is not as hard as the ED, and that clinic work is quite second rate.” (Practice GP)

This perception held by ED staff, of the lower competence of GPs led to an unwillingness to redirect patients to co-located GP clinics when they were unsure of the clinic’s quality of procedures.

“Who checks the results, who follows up the patients? For example all X-ray results are checked the next day at the ED, but who checks them at the clinic? You haven’t got the same staff there each day. So

clinically, who checks all of the things that may have been missed and results that come back?” (ED Director)

“The GPs are also unsupervised there. In the ED all junior Drs are supervised, I am not used to staff who are unsupervised, and I don’t know what their qualifications are.” (ED Director)

Furthermore this attitude affected redirections from triage nurses, resulting in a lower throughput of patients to the co-located GP clinic.

Enablers

It was seen as beneficial for the Practice Manager to encourage the GPs to be pro-active in relating to ED staff. There was a view that this would help break down some of the perceptions of competition and help the ED staff understand more about what the GPs do.

“We now get the doctors to go over and introduce themselves to the triage nurse when they start their shift.” (Practice GP)

“We don’t just sit and wait for patients, if we run out of patients the doctors go over and ask the triage nurse what is happening on the night.” (Practice Manager)

“We don’t really know, because we do not have information about what happens in the clinic, we need to work more collaboratively.” (ED Director)

Better relationships could be fostered by co-located staff attending ED professional training sessions. Another suggestion to overcome the poor communication was for co-located staff to work a shift in the ED to meet the ED staff and gain an understanding of the ED processes.

“There should be more interface between EDs and General Practice generally as both can learn from each other. People working in EDs don’t get any exposure to general practice, it seems very trivial to them.” (Practice GP)

6.9.4 Perceptions of disparity of remuneration

Barriers

There appears to be some resentment on behalf of ED staff towards what they perceived as higher remuneration for GPs (\$120 - \$130 an hour compared to \$20 for an ED trainee and \$80 - \$90 for other ED staff). This reflects the perception that GPs are not specialists and also a lack of awareness of financial obligations of GPs working in the co-located GP clinics (including medical indemnity, leave entitlements and superannuation).

“The ED manager is annoyed that the GPs are being paid \$120 per hour, because if they look at it compared to their senior registrars, they seem to be paid more highly. But to put it in context, these GPs who are at that rate or more in the normal practice. (When working in the co-located GP clinic), they are working out of hours, there is a workforce shortage and they are not paid any leave entitlements or superannuation, it is a flat rate.” (Practice Manager)

Enablers

A closer working relationship between ED and co-located GP clinic staff could help to counteract the perception that GPs do not work at the same level as ED staff.

“That perception is flawed, the ED do not take into account that there is so much work in the clinic with every new patient, more than what happens in the ED.” (Division)

However, although the rumination for GPs needs to be high to attract GPs to work in the co-located GP clinics, different models could be considered, such as linking salary increases to incentive models, to encourage higher patient throughput.

“The clinic has become busier over last few years but there is no financial incentive for the Doctors to increase their throughput as they are paid a flat hourly rate. So we are looking at some sort of incentive scheme that could help them increase throughput, such as salary packaging, or being inside the organisation so indemnity is covered.” (Practice Manager)

6.10 Well located after hours general practice clinics

The primary difference between well located and co-located GP clinics is the extent to which formal relationships exist between each clinic and the hospital to which they are ‘well located’. Co-located GP clinics have formal structures in place to facilitate ongoing communication and relationships with the hospitals in which they function.

Location was another point of difference with most well located clinics located outside of hospital property, though still within close proximity to an ED. In one case the well located clinic was located in the hospital grounds.

Consultations with well located clinics identified four overarching factors that contributed to success of well located care or acted as barriers, these reflected the issues identified in the more detailed consultations with co-located GP clinics:

- Support from local GPs and Divisions;
- Good relationships and ongoing communication between the Division, the well located clinic, ED directors and the hospital;
- Recruitment and retention of quality GPs and appropriate remuneration; and
- Funding and payment issues.

6.10.1 The purpose of well located clinics

Well located clinic Practice Managers saw their clinics as providing a service to the community, limited to treating patients who self-referred after hours and then referring those patients back to their local GPs for follow up. Practice Managers were conscious that their clinics need to balance the objective of providing after hours GP access to the community with concerns of local GPs that the clinic will be in competition to other after hours clinics.

“Our brief is clearly to diagnose, stabilise and refer.” (Well located Practice Manager)



“We record and forward a full summary of the visit to the <patient’s regular> GP each night.” (Well located Practice Manager)

At the same time, the well located clinics provided relief to local GPs, especially to busy GPs working in semi-rural areas who were often required to provide after hours services on top of normal practice work.

“The aim was to give them <the local GPs> some relief, to meet a need and to keep them longer.” (Well located Practice Manager)

6.10.2 Support by local GPs and Divisions

Support by Divisions was seen as a crucial factor in the successful functioning of the well located clinics. This was facilitated by the strong relationships with local GPs, enabling management of the tension between competition and support.

“All staff are from practices that are located from within the Division.” (Well located Practice Manager)

“There is real loyalty and a sense of community.” (Well located Practice Manager)

When local GPs had collaborated to establish the well located clinic to meet community need for after hours medical care or to relieve increasing after hours workloads, the clinic experienced few recruitment or retention problems. Strong support from local GPs enabled well located clinics to retain committed staff.

“<It was> lobbied for locally by the GPs ... they got what they wanted...you can’t do better than that.” (Well located Practice Manager)

6.10.3 Relationships and communication

Practice Managers emphasised the importance of sound relationships and ongoing communication between the Division, the well located clinic and the closely located ED. This three way relationship enabled well located clinics to deal with and quickly resolve any problems, such as determining appropriate redirection guidelines. Referring to the good relationship with the ED, one Practice Manager reported that:

“We meet regularly with the ED – the director, a regular rostered GP and the GP liaison officer.” (Well located Practice Manager)

GP liaison officers were seen as providing additional strength to the relationship between the well located clinic, the Division and the hospital. One Practice Manager observed that a GP liaison officer enabled GPs to feel they have:

“One of their own to talk to, (it’s) harder in a hospital.” (Well located Practice Manager)

6.10.4 Recruiting, retaining and remunerating quality GPs

Both well located Practice Managers consulted identified the establishment and maintenance of a workable roster as a significant challenge in the context of after hours work and shortages in the GP workforce. As with co-located GP clinics, some well located clinics had to offer the maximum per



hour pay rate permitted (\$130 per hour) to retain GPs. A different point of view put forward by one well located Practice Manager was that such hourly rates were not high enough to maintain GPs long term.

“<GPs> will become harder to recruit as they are paid minimally.” (Well located Practice Manager)

Practice Managers regarded the provision of nursing support to be a key factor in attracting and retaining GPs and a vital component to successful operation of a well located clinic. Nurses were believed to reduce isolation for GPs working in the clinics and provide an improved service to patients and GPs alike. One well located clinic operated a triage nurse advice line, similar to Nurse-On-Call but based in the clinic. This was viewed by GPs and patients as very important and well utilised. When nursing support was withdrawn due to insufficient funding, Practice Managers perceived this a significant barrier to the ongoing success of the clinic.

6.10.5 Funding and payment

The well located clinics consulted for this project operated fee for service patient billing, though bulk-billing was available for a significant percentage of patients (under 16s, over 80s and health card holders). Neither Practice Manager consulted felt that their service was financially viable without subsidies. Both Practice Managers reported difficulties in maintaining running costs, with regular government funding was required to provide an ongoing after hours medical service. Such funding allowed the well located clinics to maintain additional services such as nurses, better support systems, make improvements to premises and to pay GPs adequately.

“Ultimately we run at a break even ...The model is working well but is not on its own financially viable...it’s unlikely to be, (that’s) the reality of after hours services in difficult areas.” (Well located Practice Manager)

“I think that without any funding it could come close to making a loss.” (Well located Practice Manager)

6.10.6 Impact on EDs

The well located clinics consulted were managed through local GP Divisions and operated independently of the hospitals located nearby. The impact of both clinics on the local ED was reported as minimal, with little or no data available that identified patients that had attended the ED prior to treatment at the co-located GP clinic.

“We have not made a huge dint in <the hospital’s> ED load.” (Well located Practice Manager)

“There are no direct referrals.” (Well located Practice Manager)’

Well located Practice Managers perceived two major factors to influence the ability of well located clinics to impact on ED presentations:

- How the clinic defined their purpose; and
- The different redirection practices compared to those being used at co-located after hours clinics.

Additional factors identified as influencing the impact of well located clinics on EDs related to issues which affected under-utilisation that were similar to the co-located GP clinics. These included the poor location of the clinic in relation to the hospital, and financial disincentives associated with fee for service patient billing to potential patients who were redirected from the no cost service at the ED.

6.10.7 Redirection practices

The well located clinic Practice Managers were either unaware of the numbers of patients who were redirected from the local ED or relied on a subjective judgements and anecdotal information that the ED was busy.

The well located clinics did not actively attract direct redirections from EDs, as there were no formal arrangements with the associated ED. Practice Managers believed that patients self referred based on the information available in the closest ED. This information included:

- Wall maps displaying *all* after hours primary medical services in the local area (not just the well located clinic);
- Brochures for these services indicating practice information and opening hours;
- A displayed list of specific conditions ‘the top ten’ that could be managed by a GP clinic; and
- The introduction of a triage phone line.

The distribution of information had been negotiated with the EDs through the GP liaison officers and the Division. Practice Managers perceived this type of passive information service to work well as it managed the delicate competitive situation between after hours GP services in the area.

“We have to be fair to all members (of the Division).” (Well located Practice Manager)

6.11 The consumer perspective

Consistent with the views identified in the stakeholder consultations, the consumers’ perspective of co-located GP clinics was influenced by the quality of the relationship between the ED and the co-located GP clinic and the way in which redirections where managed by the ED.

In particular, five key factors emerged as being important to consumers, relative to after hours primary care and co-located GP clinics:

- There was a strong preference amongst patients interviewed for being treated by a GP;
- There was little awareness of co-located GP clinics;
- Patients perceived the co-located GP clinics to be part of the hospital (and assumed that they would receive similar quality of care, or that similar quality processes would be adhered to);
- Triage nurses were the key source of information for patients regarding co-located GP clinics and redirection by triage was the key factor in the redirection of consumers from the ED to the clinics; and

- Expectations of shorter waiting times were a significant factor in deciding to use co-located GP clinics.

6.11.1 Patient preference

Patients expressed a preference for being treated by a GP. However, nearly all patients first presented to an ED. Patients generally chose to visit EDs after hours because an incident occurred late in the day, or a pre-existing condition had worsened and their regular GP was closed.

Despite presenting to EDs, most patients felt that their condition was not serious enough for emergency hospital care and that a GP would be a more suitable health professional to provide appropriate care. The tension between patients' treatment preference and where they actually presented for treatment confirms the findings from broader studies (Campbell Research and Consulting, 2001) which have found a consumer preference to receive after hours treatment from a GP despite being more likely to present at EDs.

"Unless if it was actually an emergency like if I couldn't breathe or was bleeding out I would come here <to the clinic>." (Co-located GP clinic patient)

"...much more happy seeing the GP." (Co-located GP clinic patient)

Once informed of the option to receive treatment from a GP at a co-located GP clinic most patients opted to be redirected to the clinic. A common view put forward by patients for choosing redirection to a clinic was reduced waiting times. Other patients stated that a GP clinic was a more welcoming environment, this was especially the case for parents with children.

"With the little boy, he is not going to be very happy in the ED waiting room... less scary <in the clinic>." (Co-located GP clinic patient)

"A doctor's surgery is less daunting for kids." (Co-located GP clinic patient)

PCT identified patients who remained in the ED to receive treatment gave a range of reasons for doing so. Some patients were unsure as to whether the clinics could perform extra procedures such as x-rays or sutures (some triage nurses were unsure of the extent of services provided by the clinics, which added to patients' confusion). Others were reluctant to wait in another queue after already waiting a significant amount of time in the ED. When the ED was not busy and triage staff had indicated to patients that they would be seen quickly, patients saw no reason to go to another service.

Some patients did present directly to a co-located GP clinic. These patients expressed a preference for treatment by a GP and did not consider their condition serious enough to visit an ED. One point of view put forward was that patients had attended a co-located GP clinic because they could not access a GP during regular hours and the clinic provided the only way to access to a GP after hours in their area.

6.11.2 Awareness

At all four hospitals, patients interviewed were not aware of co-located GP clinics. Before presenting to the ED, most patients had not known the clinics existed. Despite all four hospitals having at least



one form of external signage for the co-located GP clinic, most patients indicated that they had not noticed this signage on route to the ED.

“There are not enough signs. But if you don’t know about the clinic you are not really looking for signs for it.” (Co-located GP clinic patient)

At the more established co-located GP clinics some patients reported previous knowledge of the general practice and their services. This knowledge came from word of mouth in the area, or referral from their regular GP (local GPs in the Frankston area provide the clinic details on their after hours answering machine services). However, previous awareness was also compromised by uncertainty regarding the opening hours of the co-located GP clinics, instances when the co-located GP clinic had been closed and the extent of services available at the co-located GP clinics. These patients said that uncertainty had influenced their decision to go directly to the ED rather than risk the clinic not being open or waiting only to find out that they would have to visit the ED anyway.

“There is confusion over the opening hours ... they are not always reliable.” (ED patient)

At the other extreme, some patients had attended a co-located GP clinic on a previous occasion but still did not recall that the hospital had a general practice clinic until the option was presented to them by a triage nurse in the ED.

Patients suggested that awareness would be improved by signage in the ED waiting room. Specific suggestions included “a large sign” (in similar format to the DHS standard ED signage) informing patients that:

1. The hospital had a general practice clinic co-located in the hospital;
2. If patients meet a certain set of criteria they could go directly to the co-located GP clinic; and
3. Co-located GP clinic opening hours, the types of procedures performed at the clinic and expected costs.

Some patients also suggested that awareness of the co-located GP clinics could be improved by brochures containing this information, which could be handed out by triage nurses or placed in the ED waiting room. Patients indicated that such additional signage would have helped them to self-refer to the clinic, reducing their waiting times and freeing up the ED.

“...defiantly <would have> gone straight to the clinic if there was signs in the ED ... anything to be seen sooner especially with a child.” (Co-located GP clinic patient)

“If the clinic was 24 hours it might free up the ED.” (ED patient)

6.11.3 Access pathways

For most patients interviewed, attendance at the co-located GP clinic followed being triaged by the ED. However, where patients had presented directly to a co-located GP clinic, patient pathways to access the co-located GP clinic included:

- Self-referral (from previous knowledge of the clinic);



- Being informed of the need to see a GP rather than the ED by the poison hotline; and
- Being informed of the co-located GP clinic from answering services of local GPs.

Patients who first presented at an ED (triage identified PCT patients) reported that they were informed of the option to be redirected to the co-located GP clinic immediately upon being triaged.

Information about the co-located GP clinics recalled by patients varied. Some patients reported only being told that they could see a GP working in the co-located GP clinic rather than waiting to be treated in the ED. Others recalled they were also informed that the co-located GP clinic was not as busy and that they would not have to wait as long.

“She <the triage nurse> was willing to take me and treat me there, but she guaranteed that I would be half the time around here <the co-located GP clinic> than at triage.” (Co-located GP clinic patient)

Where the co-located GP clinic had fee for service or co-payments, patients reported being informed that treatment at the clinic would incur a cost, though not all patients were told exactly how much.

CR&C only spoke to ED patients identified by the triage nurse on duty as being candidates for the co-located GP clinic. It should be noted that the triage nurses reported a level of uncertainty regarding which patients were suitable for the co-located GP clinic. The triage nurses’ decision of whether or not to provide the clinic option to be redirected to the clinic was also affected by:

- How busy the ED was at the time (if the ED was not busy, nurses were less inclined to refer);
- The level of information the nurses had about the clinic. Some nurses were uncertain of the clinic opening hours. Some were unsure of how busy the clinics were at the time and were reluctant to send patients around if they thought the clinics were too busy; and
- The nurses’ confidence in the skills of the clinic doctors, which related to the likeness of GPs referring patients back to the ED.

The nature of the information provided at triage strongly influenced patients’ knowledge of options for redirection to co-located GP clinics.

6.11.4 Expectations of treatment

Patients’ expectations of treatment in co-located GP clinics were influenced by the following factors:

- Perceptions of care;
- Expectations of waiting times; and
- The relationship between the ED and the clinic.

As outlined above, most patients interviewed believed that they would receive the same if not better quality of care from GPs working in the clinics, as they would from ED physicians. Some patients even felt that they would receive more focused and attentive care from a GP.

“<The clinic is> quicker...get the same level of expertise as the ED.” (Co-located GP clinic patient)

Reduced waiting time was another strong factor in patients making the decision to go to a co-located GP clinic. Patients reported that a shorter wait was often the first information provided by triage nurses about the co-located GP clinics and was usually the reason they chose to be treated at a clinic.

“You would be there <ED> 3 or 4 hours, so better to go here <the clinic>.” (Co-located GP clinic patient)

The expectation of a shorter wait was also a common reason provided by patients who presented directly to a co-located GP clinic.

“I didn't want to go to the hospital ‘cause they make you wait.” (Co-located GP clinic patient)

A Patient Satisfaction Survey conducted by Dandenong co-located GP clinic (of 145 patients) confirmed short waiting times at the clinic, 76% of patients surveyed waited under 15 minutes to be seen by GP and a further 16% waited under 30 minutes.

6.11.5 Influence of the relationship with ED

The perceived relationship between the co-located GP clinic and the ED was a very important for patients. The organisational separation of the co-located GP clinics and the hospitals was not understood by patients. Most patients perceived the co-located GP clinics to be part of the hospital. For a number of patients, this perceived relationship offered reassurance that the clinic would operate under the same quality standards and that co-located GP clinic GPs would provide the same quality of care as ED physicians.

“Part of the hospital not a separate entity ... it's all complimentary really, so you know if you need go to something else <another department>...it will have that connection and immediacy, hopefully.” (Co-located GP clinic patient)

“Part of the hospitalIt's here physically.” (Co-located GP clinic patient)

“Absolutely the same quality standards as the hospital.” (Co-located GP clinic patient)

At Dandenong and Frankston, co-located GP clinic fees were a factor considered by patients, but were not reported as being a significant deterrent. This was especially the case for parents with sick children.

“...rather pay to go than sit in the hospital for a long period of time.” (Co-located GP clinic patient)

“I would have paid anything to be quick.” (Co-located GP clinic patient)

6.11.6 Royal Children's Hospital

The RCH has a unique position because of its public image. The reputation of the RCH as *THE* specialist provider of care for children influenced different patient views relating to expectation of care. Parents took children to the RCH ED after hours specifically because of the RCH's reputation for providing 'outstanding' care for children and would drive past other, more convenient, hospitals. For some parents, expectations of high quality care translated into a willingness of RCH patients to utilise the clinic, with the assumption that the clinic doctors would operate under the same governance and

quality procedures as the RCH. This was evident in the fact that parents did not ask for specific details about the clinic GPs but assumed that they would be paediatric specialists.

“I can’t even remember if she <the triage nurse> said he was a children’s GP or a general GP.” (Co-located GP clinic patient)

The RCH’s reputation also hindered utilisation of the GP clinic. One child who presented at the ED with non-urgent condition had already seen two GPs in the previous week. Whilst the child was considered eligible for the clinic, the parents were reluctant to see another GP and instead opted to wait in the ED.

6.11.7 Case studies highlighting the patient experience

The following case studies provide three different view points of the triage identified PCT patient experience in accessing after hours care.

Case study 1 - RCH

A young boy presented to the RCH ED complaining of continuous coughing, which had been ongoing for approximately three weeks. The boy was assessed by the triage nurse as non-urgent and his parents were advised that he could see a doctor in the co-located GP clinic instead. The boy’s parents had already taken him to see two different GPs in the previous three weeks, and declined to be redirected to the GP clinic. The parents wanted to get expert advice from a RCH physician. The boy was taken back to the ED waiting room where he had to wait for an ED physician to attend to him. The ED was extremely busy that day. The boy’s parents had driven for over an hour to get to the RCH, and then decided to wait for up to four hours longer rather than see another GP.

Case study 2

A young woman in her early twenties presented to an ED after injuring her ankle on the way to the gym. She did not think that her injury was really serious enough to be at the ED but thought she might need an x-ray. She had originally gone to an after hours co-located GP clinic in her local area, but the clinic was busy and she decided the wait would be too long and that the ED would be quicker. She waited in the ED for nearly 30 minutes before being seen by a triage nurse. The nurse assessed the woman’s condition as non-urgent and suggested that she could see a GP in the co-located GP clinic rather than remaining in the ED. The woman was told that the clinic was not busy and her waiting time would be significantly less. She chose to go to the clinic and had to wait for only 15 minutes to be treated by the clinic GP. The woman felt more comfortable in the co-located GP clinic waiting room and was reassured that she would still have access to the EDs x-ray facilities if needed.

Case study 3

An elderly woman presented directly to a co-located GP clinic after getting poison in her eyes. Before attending the clinic, she had called a poison hotline and was advised that she would be able to see a GP and did not need to attend an ED. The woman's regular GP was closed and her husband had used the co-located GP clinic before, so she decided to go directly to the clinic. She did not have to go to the ED to be triaged first and was able to walk straight into the clinic. There were no patients before her and she was able to see the GP immediately. The GP that treated her condition and she was able to go home less than half an hour after first presenting at the clinic. Whilst she was not happy about having to pay a fee, she accepted that most GP services use co-payments these days stating "that if you are sick you just have to pay."

6.11.8 Dandenong Patient Satisfaction Survey

Co-located GP clinics that receive RTC funding are required to conduct a patient survey to evaluate satisfaction with the after hours services provided by the co-located GP clinic. Each organisation is allowed to develop its own survey pro forma, as long as it covers core service elements including accessibility of information, ease of making appointments, waiting time, cost of treatment and medical advice given (Commonwealth Department of Health & Ageing, 2006).

Amongst 145 patients surveyed by the Dandenong co-located GP clinic in 2006, overall patient satisfaction with the clinic was very high:

- 97% of patients said that the helpfulness and efficiency of the reception staff was excellent or very good;
- 96% of patients said that the general environment was excellent or very good;
- 94% of patients said that the clinical care provided by medical staff was excellent or very good; and
- 92% of patients said that the general information provided by the clinic was excellent or very good.

Patients surveyed also reported being provided with clear information during their consultation (99%), as well as being clearly informed of any follow up treatment required (91%).

These survey results demonstrate a high level of patient satisfaction with the co-located GP clinic and confirm the qualitative findings at one clinic location. The satisfaction rating was very high when compared with the 1997 Patient Satisfaction Survey of Victorian hospitals, in which only 87% of patients gave an overall satisfaction rating of excellent or very good (Quint and Fergusson, 1997).

The patient satisfaction survey used by the Dandenong co-located should be used as a template by other co-located GP clinics.

6.12 Key element of best practice for co-located GP clinics

The key elements of a best practice model for co-located GP clinics identified from the consultation include:

- Clearly specifying the primary purpose as reducing demand for ED services and relating other purposes to this primary purpose;
- Ensuring there is active support from local general practices, through Divisions, for both referral to the co-located GP clinic, and rostering to ensure sufficient workforce to meet available demand;
- Ensuring strong GP leadership within the co-located GP clinic by employing a GP Practice Director, at least on a part time basis;
- Ensuring that the co-located GP clinic is developed as a workplace that is supportive and inviting to GPs;
- Ensuring the leadership of the ED actively supports the co-located GP clinic through everyday management decisions and maintains clear and open communication channels between the ED and the co-located GP clinic;
- Developing clinically relevant guidelines for redirection of patients including quality processes to reflect on the suitability of patients being redirected;
- Ensuring the separate clinical and management governance of co-located GP clinics and the respective hospitals;
- Making the presence of the co-located GP clinic salient and accessible for consumers who prefer treatment from a GP, while ensuring that patients are aware of the clinic as a separate entity (not a part of the hospital but supported by the hospital);
- Ensuring that there is regular reporting of patient throughput, financial performance, patient satisfaction, referrals both to and from local general practices, identification of barriers to full implementation and availability of workforce as part of funding requirements;
- Ensuring that financial reporting reflects the accounting requirements of a business in the first instance and government reporting requirements tailored to reflect normal business accounting practices;
- Developing specific training programs for co-located practice GPs and ensuring they are made to feel welcome in the ED training program; and
- Ensuring that subsidy is available from either DHS or the Commonwealth for the co-located GP clinics to achieve financial viability.

7. Financial Analysis

7.1.1 Stakeholder perceptions of financial viability of co-located GP clinics

Stakeholders considered income sources over and above the Medicare rebate to be essential to the financial viability of the co-located GP clinics. Public subsidy (through DHS or Commonwealth grants), co-payments or direct fees were identified in the consultations as the options to increase income to achieve financial viability.

Most stakeholders identified that a consistent redirection stream would be required to maintain throughput of at least 4 patients per hour to achieve financial viability. It was considered by most stakeholders that, apart from Frankston, none of the co-located GP clinics had achieved full utilisation with throughput below 3 patients per hour in most cases.

Co-located GP clinic staff and the Divisions supported fee paying patients as the key to financial viability.

The Frankston co-located GP clinic did not charge fees for a period, which resulted in increased utilisation of the clinic for convenience rather than urgency. Patients were reported to identify when their local GP was on roster and would attend for routine general practice conditions including repeat prescriptions, screening tests and general check ups.

The financial viability of the newly established co-located GP clinics was considered to be compromised by low throughput associated with inconsistent redirections from the EDs.

7.2 Co-located GP clinic financial viability

The financial analysis conducted for this Review concluded that the co-located GP clinics are not financially viable when dependant only on Medicare bulk billing for their funding. Review of the co-located GP clinics operating results indicate that all clinics would have suffered significant losses if they did not receive DHS or Commonwealth funding.

The Frankston co-located GP clinic was assumed to be financially viable due to the fact that the clinic had higher patient throughput, charges patient fees above the Medicare rebate and had been operational for over 20 years.

From the financial information reviewed the co-located GP clinics that only serviced clients redirected from the ED will only become viable with additional funding and/or financial support.

Dandenong

The Dandenong co-located GP clinic experienced deficits of \$221k and \$137k for 2004/05 and 2005/06 respectively after receiving grant funding. Without the Commonwealth funding, the co-located GP clinic would have recorded a loss of \$178k for 2005/06. Review of the 2006/07 YTD figures indicate the co-located GP clinic is losing \$53k as at end of March 2007 after receiving a Commonwealth grant of \$112k. The average patient throughput of 3.11 patients per hour has improved on the 2005/06 patient throughput of 2.42 patients per hour.

Calculation and review of the direct costs of \$79 per patient (\$80 2006/07) indicate that the co-located GP clinic was running at a deficit when compared to the direct revenue of \$52 per patient (\$52 2006/07).

Frankston

The co-located GP clinic at the Frankston Hospital is a private for profit organisation and did not make financial data available to the CR&C team that would enable the analysis of the financial viability of the clinic.

The co-located GP clinic has been operating in the current location for 13 years. The co-located GP clinic did advise that they received \$500k in Commonwealth RTC funding since July 2005 – this funding has enabled the clinic to hire a practice nurse which has helped the doctors see more patients and service patients needs better.

The Frankston co-located GP clinic patient throughput was an average of 5 patients per hour for 2005/06 which is 2-3 patients per hour more than the other clinics. Frankston co-located patients were billed schedule fees rather than bulk billed, therefore increasing revenue for the co-located. The only patients bulk billed at the co-located were young children. All procedures are also bulk billed.

Given its period of operation as an independent organisation it is assumed that the Frankston co-located is profitable. It should be noted that the co-located GP clinic had a patient throughput of 12,622 patients in 2005/06, of which only 20%, or 2,524 patients, were redirected from the Frankston ED. In addition the centre also serviced return patients. Therefore this co-located can be considered to have an established client base and to attract patients directly rather than only treating redirections from the ED.

Northern

The co-located GP clinic at the Northern Hospital received \$260k funding from the Victorian DHS during the 2005/06 financial year and achieved a small surplus for the year after earning \$18k monthly in Medicare patient fees. In 2006/07 the clinic received funding of \$126k from the Commonwealth. Patient fees have remained constant at average of \$17.5k monthly (excluding September 2006). Without this funding the co-located GP clinic would have reported a year to date loss of \$142K.

Patient throughput figures for 2005/06 indicate the Northern co-located GP clinic was approximately 2 patients per hour on average. The direct cost per patient was over \$125 for the first two years. This was likely to have been related to the low patient throughput resulting in costs not being spread. In the

current YTD figures, where the patient throughput have increased, the direct cost per patient decreased to \$64.

Royal Children's Hospital (RCH)

The co-located GP clinic at RCH has only been operational since late 2006 and therefore limited financial data was available for this Review.

The co-located GP clinic received \$260k from DHS in 2006/07 (\$75k for capital and \$185k for operations). The co-located GP clinic budgeted to make a loss of \$185k for the first year. This budget was calculated on the assumption that throughput would average four patients per hour. However patient throughput was actually 2.0 per hour as at 31st March 2007. The year to date financials reported a small surplus of \$32k including the additional DHS funding. The result, according to the co-located GP clinic, shows a \$50k administration reimbursement from the RCH. Without the additional funding the co-located GP clinic would be recording losses. The clinic is in the early stages of operation and future throughput is likely to improve. According to the initial budget proposal for the 'co-located GP clinic at the RCH' with the level of costs budgeted, the clinic would need to service 6 patients per hour to break even.

7.3 ED non-admitted patient cost data

Only two hospitals were able to provide a breakdown of the costs attached to after hours PCT patients records identified by the VEMD.

The method of capturing costs attributable to particular patients in the ED of the hospitals is limited and is not considered to be either accurate or reliable. Nevertheless, the data produced for the cost of non-admitted patients is the first available estimates of PCT patient costs in EDs. Further work on identifying accuracy of data collected is required.

Analysis of these costs in comparison to the overall costs for the EDs is therefore difficult to reliably measure the impact of reducing the ED PCT patients. However these direct costs per patient, for the hospitals that could extract the figures, were higher direct costs than the general practice clinics. This excludes any costs for pathology, radiology or pharmacy.

The hospitals are required to record patient details into the VEMD for reporting to the DHS. These data have been used with the available costing data to estimate costs for services and care provided. However this system and the data recorded has limitations in its reliability.

The costs of services are not always known at the time of medical staff organising and providing the service and the costing system is reliant on ED staff entering the details against a patient record. As the system is reliant on the medical staff entering these data whilst caring for patients, at times when staff were under pressure, the cost allocations have not been a priority. The costs were not attached to every patient record for every service. The data provided had a very low proportion of records with pathology, radiology and pharmacy costs.

The non-admitted patient costing allocations were a theoretical absorption cost allocation of the nursing and other costs attributable to patients. There was no indication that these costs include any overheads and it is not known if these costs include any fixed or variable costs.

Dandenong

The non-admitted patient cost data extracted from Dandenong Hospital was for 8,919 after hours PCT patients for the 2005/06 financial year.

The system only records \$1.3M of costs attributable to servicing these patients. As these patients accounted for 20% of the total number of patients treated at the ED it seems unlikely that this cost allocation is accurate.

Frankston

Frankston Hospital was not able to extract the non-admitted patient cost data for the after hours PCT patients with costs attached due to limitations on the accounting software utilised for capturing the data.

Northern

Northern were not able to extract the non-admitted patient cost data for the after hours PCT patients with costs attached due to issues with their dataset (as previously known to DHS).

RCH

The non-admitted patient cost data extracted from RCH for the after hours PCT patients was provided for 18,811 patients classified as PCT patients during the 2005/06 financial year. The system records only \$2.1M of costs attributable to servicing these patients.

Given that these patients comprised 32% of all patients treated in the RCH ED it seems unlikely that this an accurate reflection of the costs attributable to treating these patients.

7.4 Direct costs and patient comparison

The direct costs attributable to providing services to a patient at a co-located GP clinic was compared to the costs of after hours PCT patients treated at the ED using the hospital non-admitted patient costing data (Table 13). Comparison of these direct costs with the cost estimate for patients treated by the clinics suggests it is more cost effective for patients to be treated by a GP in the clinic than treated in the ED.

	Dandenong 2005/06		RCH 2005/06	
After hours PCT patient numbers	8,919		18,811	
Total patient numbers	42,675		57,472	
% of Total	20.9%		32.7%	
	Total Cost	Mean Cost	Total Cost	Mean Cost
Total direct cost (Note 3)	\$1,088,053	\$121	\$1,709,622	\$91
Total indirect cost	\$253,719	\$28	\$436,587	\$23
Total cost	\$1,341,773	\$150	\$2,146,210	\$114
Scenarios for savings	Number Patients referred to GP Clinic	Potential Savings to ED 2005/06	Number Patients referred to GP Clinic (Note 1)	Potential Savings to ED 2006/07
100% of PCT patients referred to clinic	6,584	\$990,496	5,653	\$644,970
75% of PCT patients referred to clinic	4,938	\$742,872	4,240	\$483,727
50% of PCT patients referred to clinic	3,292	\$495,248	2,827	\$322,485

Note 1: RCH 2006/07 figure annualised

Note 2: Potential savings = Total cost x patients number referred to in co-located GP clinic

Note 3: Costs sourced from ED non-admitted patient cost data extracted using VEMD

Note 4: As stated previously this costing data is dependant on the ED staff accurately recording all costs attributable to servicing these patients.

Dandenong

A direct cost of \$121 per patient (total cost \$150 per patient) was estimated as the non admitted patient cost for those patients treated in the Dandenong ED during 2005/06. The co-located GP clinic estimated a direct cost of \$79 per patient. Therefore it is more cost effective to treat PCT patients in the Dandenong co-located GP clinic rather than the ED.

Frankston

Frankston hospital was not able to provide unit costing for non-admitted patients. The co-located GP clinic did not provide any financial data.

Northern

Northern hospital was not able to provide unit costing for non-admitted patients.

RCH

The non-admitted patient cost data for 2005/06 RCH ED patients provided an estimated direct cost of \$90 per patient (total cost \$114 per patient). In comparison the co-located GP clinic estimated a direct cost of \$64 per patient; therefore it is more cost effective to treat these PCT patients in the co-located GP clinic rather than in the ED.

7.5 Government subsidy per patient

The total subsidy provided by Commonwealth and State governments to the four co-located GP clinics during the 2005/06 year (2006/07 for RCH) varied from \$40k to \$260k (Table 14). The subsidy per patient varied according to patient throughput. Lower patient throughput resulted in an increased per patient subsidy.

	Dandenong YTD 2005/06	Frankston YTD 2005/06	Northern YTD 2005/06	RCH YTD 2006/07*
State subsidy	\$0	\$0	\$260,000	\$260,000
Commonwealth subsidy (note 1)	\$41,000	\$250,000	\$0	\$0.00
Total subsidy	\$41,000	\$250,000	\$260,000	\$260,000
Patient numbers (note 2)	6,584	12,622	3,108	5,653
Subsidy per patient	\$6.23	\$19.81	\$83.66	\$45.99

* - The RCH was not in operation during the 2005/06 financial year.

Note 1 - FH advised \$500k since 1/7/05 est \$250k for year

Note 2 - RCH Patient numbers annualised 2292/148 days* 365= 5,653

Dandenong

The Dandenong co-located GP clinic has not received any direct DHS funding but has recently been eligible for Commonwealth RTC funding. This co-located GP clinic had the lowest per patient subsidy due to receiving the lowest subsidy.

Frankston

The Frankston co-located GP clinic has received Commonwealth RTC funding. 80% of patients treated at the co-located GP clinic were direct “walk in” or repeat patients, with only 20% of patients being redirected from the ED. The subsidy per patient was low due to the high patient throughput.

Northern

The co-located GP clinic at the Northern Hospital had the highest subsidy per patient due the clinic having the lowest patient throughput.

RCH

The RCH clinic has only been operational since August 2006. The patient figures for 2006/07 YTD have been annualised to 5,653. The annualised subsidy is \$46 per patient.

7.6 Potential funding savings in cost and capacity

Review of funding per patient based on total budget allocation of the hospital’s NESG shows that each of the hospitals could save between \$1.2M - \$2.9M and potentially improve ED patient throughput by 12% - 33% (Table 15).

It is important to recognise that potential savings are *not cash savings* but are made through a decrease in the number of less urgent patients seen by the ED that will allow medical and nursing resources to be redirected to service more seriously ill and injured patients that present at the ED.

	Dandenong 2005/06	Frankston 2005/06	Northern 2005/06	RCH 2006/07
2005–06 recurrent budget allocation - NESG (A)	\$8,510,809	\$10,021,891	\$9,318,546	\$8,935,566
Total number of patients (B)	42,675	49,349	65,479	57,472
Total funding cost per patient (A)/(B) = (C)	\$199.43	\$203.08	\$142.31	\$155.48
Number of after hours PCT Patients (D)	8,919	5,956	19,123	18,811
Estimated funding costs of servicing PCT (C) *(D) - potential funding savings	\$1,778,744	\$1,209,556	\$2,721,461	\$2,924,675
Potential capacity savings	21%	12%	29%	33%
Number of patients referred to GP Clinic (Note 2&3) (E)	6,584	2,524	3,108	2,292
Savings by sending patients to the GP Clinic (E)*(C)	\$1,313,068	\$512,660	\$442,310	\$356,353
Percentage of total patients – excess capacity	15%	5%	5%	4%

Note 1 - The above estimated costs are based on the Budget allocation

Note 2 - RCH figure from 2006/07 part year

Note 3 - Frankston clinic advise that only 20% of the patients are referred from the ED 12622*20% = 2524

Please note that funding savings are opportunities for ED resources to be reallocated to treat Non PCT patients

Dandenong

Treating Dandenong ED after hours PCT patients in the co-located GP clinic, could result in a potential saving of 21% of capacity and \$1.7 M.

Frankston

\$1.2 M and 12% of capacity could potentially be saved by treating after hours PCT patients from the Frankston ED in the co-located GP clinic. However, it must be noted that the number of after hours PCT patients presenting at Frankston is lower than at the other three hospitals.

In addition, it must be noted that DHS figures show a higher per patient funding cost for Frankston; however this may reflect existing PCT patient redirection and the higher acuity of patients treated by the ED.

Northern



Similarly, treating Northern after hours PCT patients in the co-located GP clinic could potentially free 29% of ED capacity and save up to \$2.7 M.

RCH

Analysis of the RCH annual budget for 2006/07 and the number of patients treated reveals a per patient average cost of \$155. To treat the after hours PCT type patients in the co-located GP clinic has the potential to free up to 33% of ED capacity and return a saving of \$2.9 M.

7.7 Financial impact and staffing implications for EDs

Neither the consultation nor the financial analysis identified specific issues about the staffing structure of EDs. From the analysis of the VEMD data there is an indication that demand for PCT presentation to EDs is being contained. It is not clear the extent to which the co-located GP clinics are contributing to this containment, particularly in the light of their current state of under-utilisation.

In Frankston, where the clinic has been well established, the impact of the ED has been a lower proportion of PCT presentations and a higher overall acuity of patients presenting to the ED. The higher acuity is associated with a higher funded cost per ED patient (row C, Table 15).

The consultations identified a concern that EDs could be disadvantaged should the co-located GP clinics successfully reduce the number of non-admitted patients attending. If the number of non-admitted patients fell the ED may be adversely affected because of the calculation of rations of non-admitted patients from the state based average. However, although the current NESG funding formula compensates for increased acuity, it is recommended that the future impact of the co-located GP clinics on ED presentation should be monitored, and the funding formula reviewed to ensure there are no disincentives for EDs to refer or recommend patients attend.

8. Conclusion

The Review found that special purpose after hours co-located general practice clinics are not financially viable without public subsidy if they are to provide services of an appropriate quality without some public subsidy. Evidence gathered for the Review indicates that the co-located, together with the well located clinics, are containing demand by PCT patients in EDs. However, the clinics require strengthening and future developments require consistent monitoring and evaluation to confirm the impact of the co-located clinics.

Clarification of the primary purpose of co-located GP clinics from the DHS perspective is required if DHS is to continue to fund the clinics. Any funding should be attached to agreement to ongoing monitoring and evaluation against agreed criteria.

If the definition of a co-located GP clinic is “a clinic that is subsidised directly or indirectly by DHS or the hospital” is accepted, the co-located GP clinic at Frankston hospital would be more appropriately described as a *well located* clinic. New co-located GP clinics should only be considered where there is a local need identified by high demand for ED services by PCT patients, low levels of after hours service provision by local practices and support for both referral to, and roster participation in, co-located GP clinics by local practices.

Analysis of the VEMD data did not demonstrate a clear and direct impact from newly established co-located GP clinics. However, the analysis did suggest that the clinics are stemming the growth in demand for PCT services in ED clinics. The data indicates that the growth in PCT presentations during the time when the clinics are open is *lower* compared with growth for after hours PCT presentations as a whole. It is also clear that the growth demand for after hours PCT services is lower than the growth in demand for *EDs* as a whole.

These effects were not uniform across the clinics, with some clinics suggesting greater impact on demand and acuity in EDs than others. The evidence from Frankston, in particular, indicates that a well established clinic located in the hospital that is supported by local GPs and where patients can directly access services has resulted in a lower proportion of PCT patients presenting to the ED and a higher acuity of the ED patient load.

The key characteristics of a well functioning co-located GP clinic identified through stakeholder consultation include:

- Separate and clear management and clinical governance responsibilities for the clinic;
- GP leadership within the clinic;
- Well established relationships and communication channels between the co-located GP clinic and the ED;
- Specific training around ED scope of practice and its inclusion in established continuing professional development programs for staff of co-located GP clinics; and
- The establishment of recognised quality standards.

For successful viability, the support of local GPs both through referral of patients and participation in rosters is a vital ingredient for success and ongoing viability of the model. There is also a clear need for the development and ongoing quality improvement redirection guidelines for triage staff in EDs. Strengthening the clinics to achieve these guidelines is recommended.

The consultations and analysis of financial data clearly identified that the co-located GP clinics are not achieving their full capacity and are currently underutilised. Strengthening the clinics is likely to result in an increased proportion of the PCT patient load from EDs being taken up by co-located GP clinics.

The effectiveness of the continued impact of co-located GP clinics of ED demand will require ongoing monitoring. Any monitoring should also include newly established well located clinics, particularly as current Commonwealth funding is time limited and the likelihood is limited for special purpose after hours clinics to be independently financially viable and, at the same time, provide services of an appropriate quality.

The co-located GP clinics also offer the potential for achieving the goals of both Commonwealth and Victorian Government policy of strengthening the integration hospitals with community based services as represented by general practices.

It is clear that the development of general practice clinics that are either co-located or well-located requires the ongoing collaboration of the Victorian and Commonwealth Government. It is not considered likely that single purpose after hours clinics are likely to be financially viable in the immediate future. Co-ordination of policy and support with shared information about performance and planning for this service model is essential for its long term viability.

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APPENDIX 1

Clinical governance issues associated with after hours co-located general practice clinics



1. Clinical Governance

During consultation for this co-located general practice project, some emergency physicians indicated that:

- they have a strong sense of responsibility for the quality of care provided to patients who present to their departments; and
- they are concerned about facilitating (either actively or passively) access by patients to independently-run general practices when they have little or no knowledge of or control over the clinical governance systems that apply in those general practices.

This issue appears to be creating a significant barrier to cooperation between some co-located emergency departments and general practices.

1.1 What is clinical governance?

Clinical governance is an important component of the overall governance responsibility of health care organisations. The Organisation for Economic Co-operation and Development provides the following definition of corporate governance:

"Corporate governance is the system by which business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different participants in the corporation, such as the board, managers, shareholders and other stakeholders, and spells out the rules and procedures for making decisions on corporate affairs. By doing this, it also provides the structure through which the company objectives are set, and the means of attaining those objectives and monitoring performance."⁴

Another useful definition is provided by Deloitte Touche Tohmatsu:

"Corporate governance is, in its broadest sense, the stewardship responsibility of corporate directors to provide oversight for the goals and strategies of a company and to foster their implementation."⁵

We believe that clinical governance has the same characteristics as corporate governance. Leadership, clear delegation of responsibility, quality systems, monitoring, accountability and management of risk and essential elements of strong governance systems, whether clinical or corporate.

We consider, therefore, that a sound clinical governance system requires:

- strong organisational leadership with a focus on clinical performance;
- delegation of responsibility from the board or governing body to management and throughout the organisation, with clarity of who is responsible for which aspects of the quality of clinical care;

⁴ <http://www.encycogov.com/WhatIsGorpGov.asp>

⁵ Conformance or performance and other dilemmas in corporate governance
[http://www.deloitte.com/dtt/cda/doc/content/Deloitte-WEF\(1\).pdf](http://www.deloitte.com/dtt/cda/doc/content/Deloitte-WEF(1).pdf)

- implementation of quality systems that enable employees and others to provide quality clinical services;
- accountability for performance, by employees and others, to the board or governing body;
- robust monitoring systems that continuously evaluate and respond to clinical quality issues; and
- strong systems of clinical risk management.

It is widely accepted that in professional areas it is not possible to develop sound clinical governance systems without the engagement of the professionals who provide services. In health care organisations, it is vitally important that medical, nursing and allied health professionals are engaged in the design, implementation and monitoring of clinical governance systems.

1.2 Trends in clinical governance

In Australia and internationally, following a number of clinical governance failures, health care organisations have implemented significantly more robust systems than applied in the past. The focus on clinical governance has not been confined to hospitals - there is increasing impetus in the general practice setting for the development of sound quality and accountability systems.

There are several well-regarded organisations that provide accreditation services to hospitals and general practices and most Australian hospitals and general practices are accredited. It is widely accepted, however, that whilst accreditation is useful it provides insufficient evidence to assure a governing body of the robustness and resilience of an organisation's clinical governance systems.

In addition, it has been suggested to the project team that the services provided by co-located general practices are, by their nature, different from usual general practice services and standard general practice accreditation systems may not be useful because:

- the patient mix is limited to patients seeking emergency care;
- there are very high patient turnover rates; and
- the nature of the practice means that there is little if any ongoing care.

Many stakeholders consider that clinical governance generally is more robust in large organisations with substantial quality infrastructure and independent boards, compared with small general practices where there often is less sophisticated infrastructure and there is no separation between those who provide clinical services and those who govern their quality.

1.3 Regulatory and legal issues

1.3.1 Responsibility not to direct or refer

The Australian Health Care Agreement between Victoria and the Commonwealth:

- allows Victorian hospitals to provide information about alternative service providers; but



- obliges hospitals to provide free treatment if the patient chooses to be treated at the hospital.

Hospital employees may advise patients about alternative options for care from a co-located general practice, but they must not refer or direct patients to those practices. ⁶

The issue of concern to emergency physicians is whether, even if emergency department staff simply facilitate access to independent general practices which are co-located or well located, there is a legal or ethical responsibility to ensure that the quality of care offered by those providers is of a reasonable standard.

1.3.2 General duty of care

Although discussion during consultation focused on service quality rather than on medico-legal liability, the law of negligence provides a useful framework for considering this issue.

For negligence to be established, it must be shown that:

- there was a duty of care;
- the duty of care was breached; and
- the breach caused damage to the client of a kind that was reasonably foreseeable.

In almost all circumstances a general duty of care can be demonstrated readily between a hospital and its health care professionals on the one hand, and a patient who presents to the hospital's emergency department on the other.

The duty owed by one party to another is to exercise reasonable care. The hospital will be vicariously liable for the actions of its employees if they breach their duty of care to the patient. The duty can be breached in all of the situations in which a professional is called upon to exercise his or her skill and judgement.

The standard of care that applies to a professional has been defined in the *Wrongs Act 1958* as follows:

"A professional is not negligent in providing a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by a significant number of respected practitioners in the field (peer professional opinion) as competent professional practice in the circumstances."

However, peer professional opinion cannot be relied on for the purposes of this section if the court determines that the opinion is unreasonable.

....

*"Peer professional opinion does not have to be universally accepted to be widely accepted."*⁷

⁶ Clause 39, Australian Health Care Agreement between Victoria and the Commonwealth, 2003-2008.

⁷ Section 59, *Wrongs Act 1958*.

Section 60 of the *Wrongs Act 1958* provides that: this standard does not apply to a liability arising in connection with the giving of (or the failure to give) a warning or other information in respect of a risk or other matter to a person if the giving of the warning or information is associated with the provision by a professional of a professional service. In such 'information' cases, the applicable standard of care is determined by the court.

Clearly, the triage process needs to be conducted according to an appropriate standard of care and there are medico-legal risks associated with that process even if hospital staff do not advise patients of a co-located general practice option. Incorrect triage, for example, which results in a patient waiting an excessive period of time before leaving without being seen and subsequently suffering foreseeable harm could, in certain circumstances, amount to negligence.

We are unaware of any reported cases which define the standard of care that applies when a patient presents to an emergency department, is triaged and advised that alternative treatment options may be available. We note, however, that:

- it is common practice to advise patients of alternative treatment options and the practice of doing so *per se* is unlikely to amount to a breach of the duty of care even if the test of being 'widely accepted by a significant number of practitioners in the field' does not apply because of the effect of section 60 (above); and
- the alternative practice of 'triaging' a patient and advising them to wait, sometimes for prolonged periods of time which may result in them leaving before being seen by a health care professional, carries its own medico-legal risks.

On balance, we consider that the practice of advising appropriate patients of the availability of a credible alternative service is unlikely to amount to a breach of duty of care and may in fact be characterised as an enhancement to the quality of care.

1.3.3 Potential non-delegable duty to ensure care is taken

The question remains, however, as to whether there is an obligation to ensure that care provided by providers to whom a patient is redirected or referred is provided at an appropriate standard.

It should be noted that:

- in usual circumstances there is a significant element of patient choice in any referral from one health care provider to another;
- there is a robust regulatory framework around the provision of health care by registered professionals and it may be reasonable to assume that any registered medical practitioner is competent to provide services to patients who are assessed as not requiring immediate care in a hospital emergency department; and
- when emergency departments refer a patient to a local general practitioner for continuing care, they do not undertake a clinical governance 'audit' of the practice to which the patient is being referred.

We are unaware of any circumstances where a health care practitioner has been held responsible for the negligent treatment of a patient properly referred to another practitioner. On the other hand, there are

some features of co-located general practice arrangements that may raise a specific duty of care for emergency departments when they advise patients who present to them that they may choose to use the services of those practices. We consider that in some circumstances, a 'non-delegable duty of care' may apply in addition to general and vicarious duties of care.

A non-delegable duty of care arises when there is a special relationship between parties that generates a special responsibility or duty to ensure that care is taken, even if services are provided by a third party.

In determining whether or not a non-delegable duty of care exists, it is essential to identify the particular services a hospital undertakes to provide to the patient. This is a question of fact in each case. An important case involving hospitals is *Elliott v Bickerstaff*⁸. In that case, the Court of Appeal had to decide whether a surgeon operating on a patient at a private hospital owed a non-delegable duty of care to the patient. The Court of Appeal said that the important question is:

"When will the content of a person's duty be such that the person owing the duty of care must ensure that the third party exercises reasonable care in place of that person, so that he is liable if the third party does not do so?"

...

It is necessary first to identify the scope of the hospital's duty of care in the hospital/patient relationship because of the different roles of those involved in providing medical and associated services to the patient. If the hospital's undertaking extends to provision of the surgeon's services, the hospital must ensure that the surgeon exercises reasonable care in its place. But if the undertaking does not extend to provision of the surgeon's services, categorising the hospital's duty of care as non-delegable will not make the hospital liable if the surgeon (not being a servant or agent of the hospital) is negligent.

*The same necessity arises when considering a surgeon's duty of care to a patient, because the surgeon will commonly be one member only of a team attending to the patient and those involved in providing medical and associated services to the patient have different roles: see *Van Wyk v Lewis* and the other cases considered above.⁹*

We note the statement of Mason J in *Kondis v State Transport Authority*¹⁰:

*"The element in the relationship between the parties which generates a special responsibility or duty to see that care is taken may be found in one or more of several circumstances. The hospital undertakes the care, supervision and control of patients who are in special need of care. The school authority undertakes like special responsibilities in relation to the children whom it accepts into its care. If the inviter be subject to a special duty, it is because he assumes a particular responsibility in relation to the safety of his premises and the safety of his invitee by inviting him to enter them. And in *Meyers v Easton* the undertaking of the landlord to renew the roof of the house was seen as impliedly carrying with it an undertaking to exercise*

⁸ (1999) 48 NSWLR 214.

⁹ At paras 96-97.

¹⁰ (1984) 154 CLR 672 at 687.

reasonable care to prevent damage to the tenant's property. In these situations the special duty arises because the person on whom it is imposed has undertaken the care, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised." (our emphasis).

Gaudron J in *NSW v Lepore*¹¹ has characterised a non-delegable duty as a positive duty to take reasonable care, with the positive nature of the duty referring to the fact that the duty is generally a duty to do something specific, such as provide a safe system of work or a safe school environment.

The relationships that give rise to a non-delegable duty to ensure that reasonable care is taken are marked by the central features of control on the one hand and vulnerability on the other.

In several cases which are not specific to the situation of co-located general practices, the relationship between a hospital and patient has been recognised as giving rise to a non-delegable duty of care.

If a non-delegable duty of care exists, an organisation cannot avoid liability by relying on delegating responsibility to a third party, even if the delegate is competent.

Whether a non-delegable duty of care applies in a co-located general practice situation is untested in the courts and cannot be answered with certainty. It should be noted, however, that it seems clear from the consultation with patients conducted as a component of this project that patients may assume that co-located general practices that are operating from within hospital premises are to a large extent 'part of the hospital' and subject to the hospital's clinical governance systems. The co-located hospital's control of the environment is likely to be a significant factor that favours the existence of a non-delegable duty. The duty may differ, for example, in situations where a clinic is located on hospital grounds but has a separate entrance, signage and identity.

1.4 Recommended approach to clinical and medico-legal risk management

1.4.1 Assume a duty of care and/or ethical obligation exists

A conservative position would assume that a hospital is subject to a non-delegable duty of care for services provided by co-located general practices to patients who present initially to the hospital, particularly if those general practices are physically located in a manner that implies that they are part of the hospital.

There are specific clinical risks relevant to the type of care being provided in co-located general practices. High patient turnover rates, high professional turnover rates and lack of follow up because of the nature of the practice all raise clinical risks that need to be managed.

In addition, there are reputational and ethical issues that favour the co-located hospital taking an active risk management role.

¹¹ (2003) 212 CLR 511 at 545.

We recommend that co-located hospitals and general practices institute a specific risk management approach with the following main objectives:

- appropriately allocating risk and in particular minimising the likelihood that the hospital will be held to owe a non-delegable duty of care; and
- ensuring that appropriate systems are in place to address reputational, ethical and medico-legal risks.

1.4.2 Minimise the likelihood that a non-delegable duty of care will be held to exist

To reduce the risk that a non-delegable duty of care will be held to exist:

- hospitals should make it clear to patients that co-located general practices are operated independently of the hospital, by persons or organisations other than the staff of the hospital (if this is the case);
- protocols should be agreed between the hospital and the co-located general practice as to how the relationship will be explained to patients;
- signage and written information should explain clearly the relationship between the general practice and the co-located hospital; and
- patients could be asked to sign a document stating that they understand that the co-located general practice is an independent service, but this may be impracticable in the circumstances.

1.4.3 Manage reputational, ethical and medico-legal risks

Even if a non-delegable duty of care exists, it does not imply strict liability and is amenable to management. Rather than being a duty to ensure that patients are not harmed, the hospital's duty, if a non-delegable duty of care exists, is to ensure that it establishes safe systems of operation for its own and associated services that comply with reasonably and objectively assessed contemporary standards.

In addition, there are reputational and ethical risks for both parties if care is not provided to an adequate standard of quality.

These reputational, ethical and medico-legal risks can and should be managed through agreement between the co-located hospital and the general practice on the implementation of sound risk management clinical governance systems. Agreements should cover the way in which the parties will cooperate to jointly manage and improve quality.

General practice representatives were adamant during consultation for this project that they have instituted appropriate quality systems and are proud of the quality of care they provide. Reaching agreement on clinical governance systems should not be difficult; will provide a high level of reassurance for both parties; and will assist both parties to manage reputational, ethical and medico-legal risks.

There is a shared interest in clinical governance issues and the responsibility to demonstrate appropriate quality systems should not apply to both the co-located general practice and the hospital. Co-located



general practices also have a legitimate interest in the quality of triage by the emergency department and both parties are likely to have access to clinical information which is relevant to the quality of the other party's services and should be accessible for quality improvement purposes.

Where a general practice is governed by the co-located hospital, the hospital's clinical governance systems should be applied. Specific clinical standards will apply because of the nature of the patient mix and the need for coordination and integration of clinical protocols with the hospital's emergency department, but the hospital's general governance responsibility to ensure that the usual range of risk management, clinical quality, monitoring and accountability systems apply is not diminished under such circumstances because the service is a general practice service.

Where a general practice is governed independently of the co-located hospital, agreements between the parties should address:

- the standards that will apply to the clinical care, including advice on service options that will be provided by each party;
- the clinical risk management, quality monitoring and accountability mechanisms that will apply;
- the insurances that will be held; and
- the way in which the parties will share information relevant to clinical quality and address clinical quality concerns.

One of the potential benefits of co-located general practices is the opportunity they provide for involved practitioners to access educational and quality programs within acute hospitals. The development of shared quality activities offers a significant opportunity in this regard.

The simplest method of ensuring that appropriate clinical governance systems are adopted in such circumstances would be via contractual agreements associated with the lease or licensing of hospital facilities to the co-located general practice. If a co-located general practice is operating in facilities that are not owned by the hospital, the legal mechanisms for effecting relevant agreements will vary but the standards, intent and outcomes of such agreements should not.

The Department of Human Services, in progressing its co-located general practice policy, could consider sponsoring a project to develop a clinical governance template to be applied by hospitals and general practices developing collocation agreements.