Appendix 2: After Hours needs assessment report, NTML.

medicare local
NORTHERN TERRITORY
Connecting health to meet local needs

Northern Territory Medicare Local
After Hours Needs Assessment Report
March 2013

Northern Territory Medicare Local

Darwin Office:

5 Shepherd Street

Darwin NT 0800

GPO Box 2562

Darwin NT 0801

Telephone 08 8982 1000

Facsimile 08 8981 5899

Alice Springs Office:

5 Skinner Street

Alice Springs NT 0871

PO Box 1195

Alice Springs NT 0871

Telephone 08 8950 4800

Facsimile 08 8952 3536

ABN 17 158 970 480

The Northern Territory Medicare Local acknowledges the financial and other support from the Australian Government Department of Health and Ageing.

Table of Contents

Table of Acronyms

ACRONYM	MEANING
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisations *also known as Aboriginal Medical Services*
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Association of the Northern Territory
Anyinginyi	Anyinginyi Health Aboriginal Corporation
ASAP Clinic	Alice Springs After Hours General Practice Service
CARPA Manual	Central Australian Rural Practitioners Association Manual
Congress	Central Australian Aboriginal Congress
DoH	Department of Health *Northern Territory Government*
DoHA	Department of Health and Ageing *Australian Government*
ECP Program	Extended Care Para-medicine Program
GP	General Practice or General Practitioner
GPNNT	General Practice Network of the Northern Territory
GPAH Grant Program	General Practice After Hours Grant Program
IMG	International Medical Graduate
MBS	Medicare Benefits Schedule
Miwatj	Miwatj Health Aboriginal Corporation

ACRONYM	MEANING
NAPLAN	National Assessment Program – Literacy and Numeracy
NT	Northern Territory
NTML	Northern Territory Medicare Local
PATS	Patient Assistance Travel Scheme
PBS	Pharmaceutical Benefits Schedule
PIP Payments	Practice Incentive Program Payments
PUCAHS	Palmerston Urgent Care After Hours Service
RFDS	Royal Flying Doctor Service
RMP	Remote Medical Practitioner *Formerly known as District Medical Officer*
Wurli	Wurli Wurlinjang Health Service

Executive Summary

Medicare Locals have been established as part of the *National Health Reform Agenda* to coordinate primary health care delivery, tailor services to meet the needs of local communities, and to tackle local health care needs and service gaps.

Significant Australian Government funding is being channelled through Medicare Locals for health programs, including chronic disease management, aged care, and mental health. Medicare Locals are also funded to undertake primary health care capacity building programs such as e-Health, workforce development, training and practice support.

The Northern Territory Medicare Local (NTML) is uniquely positioned amongst Medicare Locals in Australia. The NTML developed from an innovative partnership between the Associate Membership of the former General Practice Network of the Northern Territory, the Aboriginal Medical Services Alliance of the Northern Territory and the Northern Territory Department of Health. This collaboration has placed the NTML firmly at the centre of primary health care in the Northern Territory, and enabled us to capitalise on these established relationships in our engagement with providers and consumers of health care.

One of the initial roles the NTML undertook was a needs assessment identifying gaps in access to after hours primary health care.

In addition to the After Hours Project, all Medicare Locals are required to undertake a comprehensive Needs Assessment on Primary Health Care Services. The NTML combined consultations with the After Hours Project where possible, to ensure that stakeholders were consulted thoroughly on Primary Health Care issues, and to reduce consultation fatigue.

Consultations took place in February and March 2013, with site visits conducted in Darwin, Palmerston and the Greater Darwin area, Alice Springs, Katherine, Tennant Creek and Nhulunbuy. Providers and representative groups were interviewed, data was reviewed and analysed, and relevant research and reports were appraised.

Key findings of the After Hours Needs Assessment were:

- The availability of after hours services varies significantly across the Northern Territory. Residents in Darwin have access to the greatest number of after hours services, including bulk-billing services, extended hour pharmacies and an overnight Urgent Care Service;
- Issues of remoteness (including transport, infrastructure and limited available services) has a large impact on the delivery and availability of after hours services;

- In remote areas, the requirement of staff to deliver after hours on-call services has a significant impact on health education programs delivered during the day. This then has a consequent impact on the population's health, and subsequent need for after hour services;
- Workforce issues including recruitment, retention and staff burn-out have a major impact on the delivery of after hours services;
- There is a lack of clear and consistent data on utilization of after hours services, particularly of GP services;
- There is an apparent lack of consumer knowledge on available after hours services;
- There are limited after hours services in regional centres, with a reliance on public hospital Emergency Departments to provide after hours services for primary health care matters; and
- There is a disparity between perceived consumer response (by providers) to advice from Health Direct Australia when compared with service use data provided by Health Direct Australia.

The Northern Territory Plan on After Hours Primary Health Care will develop practical and innovative strategies and services to help improve access to after hours services for all Territorians. This will include working with providers of existing after hours services and other stakeholders, to capitalise on what is working well in local areas. To achieve this, the NTML has recommended that DoHA approve the allocation of funding to the following strategies and services:

- A continuation of existing After Hours Practice Incentive payment scheme through the NTML. This ensures services currently delivering after hours are maintained, and will enable the collection of data on after hours service use so that an assessment can be made on whether any modifications are required in 2014/15;
- A limited expansion of the After Hours Practice Incentive Payment to eligible services from January 2014, with a particular emphasis on providers in remote areas;
- In consultation with local providers and community, develop and implement service models for after hours service delivery in Alice Springs, Katherine and Tennant Creek, building on existing services where possible;
- Develop and deliver health education campaigns on after hours services, including resources on existing after hours services;
- Continuation of the trial to provide an additional community health worker to provide support for after hours on-call work through the Ngalkanbuy Health Centre on Elcho Island; and
- Continuation of the trial to provide additional community health workers to provide after hours on-call work at the Birany Birany Outstation and Dhalinybuy Outstation.

The NTML is committed to establishing ongoing processes for engaging with the health workforce, the community, stakeholder groups, partner organisations and peak bodies. We see the After Hours Project, together with the Needs Assessment on Primary Health Care Services, as a fundamental first step in this engagement.

We look forward to receiving advice from DoHA on the recommendations identified within the Northern Territory Plan on After Hours Primary Health Care. We also look forward to working with our stakeholders, with providers and with the community in the development and implementation of these plans.

29 March 2013

Dr Andrew Bell **Debbie Blumel**

Chair **Chief Executive Officer**

Acknowledgements

The Northern Territory Medicare Local (NTML) would like to acknowledge the contribution of the individuals, agencies and organisations that assisted in the development of the After Hours Needs Assessment Report, and the accompanying Northern Territory Plan on After Hours Primary Health Care.

Particular thanks are given to:

- The many individuals and groups who participated in the consultations. The NTML appreciates their valuable time, local knowledge and input;
- The After Hours Project Sub Committee for their time and expertise;
- The NTML's partners and co-owners, the Aboriginal Medical Services Alliance of the Northern Territory, the Northern Territory Department of Health and the Associate Membership of the former General Practice Network of the Northern Territory;
- The Australian Medicare Local Alliance;
- The Darwin office of PricewaterhouseCoopers for work on both stages of the After Hours Program;
- The NTML Board and Chief Executive Officer; and
- The NTML staff who worked on Stage 1 and Stage 2, and all other staff members who made contributions and otherwise provided assistance and support.

The NTML also gratefully acknowledges the financial and other support from the Australian Government Department of Health and Ageing.

Refer to the Appendices for a full list of consultations undertaken in the development of this report and the NT Plan.

Introduction

After hours primary care is accessible and effective care for people whose health condition is urgent and cannot wait for treatment until regular services are next available.[1]

Program Background

In 2010, as part of the *National Health Reform Agenda*, the Australian Government announced the establishment of Medicare Locals, with the intention that Medicare Locals would improve coordination and integration of primary health care in their local communities.

The aim of the Australian Government's after hours primary health care reforms are to provide all Australians, regardless of where they live with accessible and effective after hours primary care services. To achieve this, Medicare Locals are required (amongst other things) to[2]:

- facilitate an improved patient journey by coordinating and promoting access to after hours services within their geographic boundary;
- design and develop a response to address priority gaps in after hours primary care within their geographic boundary; and
- ensure sound clinical governance and effective management of the after hours services they fund

Medicare Locals across Australia will lead the development of the After Hours Program in their catchment area, to take into consideration new funding arrangements for after hours primary health care, from 1 July 2013.

In completing this needs assessment and developing the Northern Territory Plan on After Hours Primary Health Care Services (the Plan), the NTML aims to:

- ensure that local after hours primary care services are well planned, coordinated and appropriate to the community's needs;
- ensure that patients are directed to the most appropriate point of care for their condition, wherever they live;
- fund additional services to expand and support after hours service provision;
- provide a smooth and transparent transition to the new funding arrangements, minimising the administrative burden on services; and
- ensure that ongoing evaluation and monitoring of services is undertaken, to ensure provision of the most appropriate, accessible and effective service for patients.

The Australian Medicare Local Alliance has identified the following international trends and issues in the provision of after hours care (referred to as out of hours care or extended care)[3]:

[1] Department of Health and Ageing, *Medicare Locals - Guidelines for after-hours primary care responsibilities until 30 June 2013*, 2011
[2] Ibid

- A shortage of General Practitioners;
- General Practitioner workload pressures, including the desire of many General Practitioners to opt out of the provision of after hours care, particularly in the unsociable after hours period between 11 pm and 7 am;
- An overall growth in demand for after hours services, especially due to ageing populations;
- Access issues, relating to the cost of receiving the service, and in remote areas with low population densities;
- Growth in demand for self-referred primary care or General Practice type services in public hospital emergency departments;
- Shift away from local practice based models to organized cooperative local or regional models;
- The introduction of telephone advice and triage services; and
- Improved links between public hospital emergency departments and ambulances, with primary care services.

These factors provide a useful basis from which to assess the issues and needs in the NT and to determine any similarities and differences that would need to be addressed in the NT Plan on After Hours.

As a Tranche 3 Medicare Local, the NTML was initially tasked with undertaking a needs assessment on after hours services for a sub-region within the NT. The NTML Stage 1 needs assessment was undertaken in the East Arnhem Region, with consultations occurring in September 2012. Funding was provided to the NTML for allocation to the following services, which will commence operation in April 2013:

- Additional community health worker to provide support for after hours on-call work through the Ngalkanbuy Health Centre on Elcho Island;
- Additional community health workers to provide after hours on-call work at the Birany Birany Outstation and Dhalinybuy Outstation; and
- Project to develop data collection and after hours service protocols in the East Arnhem region across a range of Government and non-Government health service providers.

Under Stage 2 of the After Hours Program, the NTML completed a needs assessment on after hours medical services across the entire Northern Territory, to inform the development of a Northern Territory-wide plan on after hours primary health care, to be implemented and funded from 1 July 2013. This needs assessment has helped the NTML to:

- identify current after hours services;
- start developing a picture of who is using after hours services and why;
- identify any localized and systemic gaps in accessing after hours services;
- identify any localized and systemic barriers in providing after hours services; and

[3] Extracted from: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/medilocals-ahresp

- identify and develop strategies to improve access to after hours primary health care services in the NT, including developing new services or enhancing existing services.

Project Methodology

The following activities were undertaken during the preparation of this report:

- Service Mapping and Research Review

A comprehensive and up to date service map was developed, highlighting available after hours services. This was completed by reviewing directory's and other information developed by the NTML and other relevant agencies, including the General Practice Network of the Northern Territory, and the Northern Territory General Practice Education organisation.

A review of relevant research and reports was also undertaken, with publications considered from the Menzies School of Health Research, the Health Gains Unit (Northern Territory Department of Health), and the Centre for Remote Health. These publications were considered in light of their relevancy to current after hours service delivery, including workforce and accessibility issues.

Refer to the Reference section for a full list of sources.

- Stakeholder Engagement and Consultation

Stakeholder engagement and consultation activities were conducted across the NT, with travel outside Darwin undertaken to Nhulunbuy, Katherine, Tennant Creek and Alice Springs. Services in Darwin, Palmerston and Greater Darwin were also consulted.

Consultations occurred with almost every General Practice in the NT, staff from the five public hospitals, eight Aboriginal Community Controlled Health Organisations (ACCHO), and other relevant provider groups. Specific networks were also consulted, including the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) Member Operations Reference for Public Health group and the Nhulunbuy Clinical and Public Health Advisory Group.

As the only provider of ambulance services in the Northern Territory, discussions were held with St John Ambulance representatives in Darwin, Katherine and Nhulunbuy.

Non-health service groups were also consulted, including local councils, and other support services.

The NTML has a commitment to engaging with consumers of after hours health services. This will be an ongoing process throughout 2013/14, through the Consumer Advisory Group, which will report to the NTML Chief Executive Officer.

Refer to Appendix M for a full list of consultations undertaken.

- Data review and statistical analysis

A range of data, including Medicare Benefits Schedule data, population demographics, and patient service utilisation rates was reviewed and analysed. Data came from a range of sources, including a selection of General Practices and ACCHO, the Australian Bureau of Statistics, Medicare Australia, the Australian Institute of Health and Welfare, the Australian Medicare Local Alliance.

Information was also provided by the Department of Health and Ageing regarding Practice Incentive Program payments, and General Practice After Hours Grants.

Project Governance

All Medicare Locals are required to undertake a comprehensive Needs Assessment on Primary Health Care services. The NTML combined consultations with the After Hours Project where possible, to ensure that stakeholders were consulted thoroughly on Primary Health Care issues and to reduce consultation fatigue by the NTML.

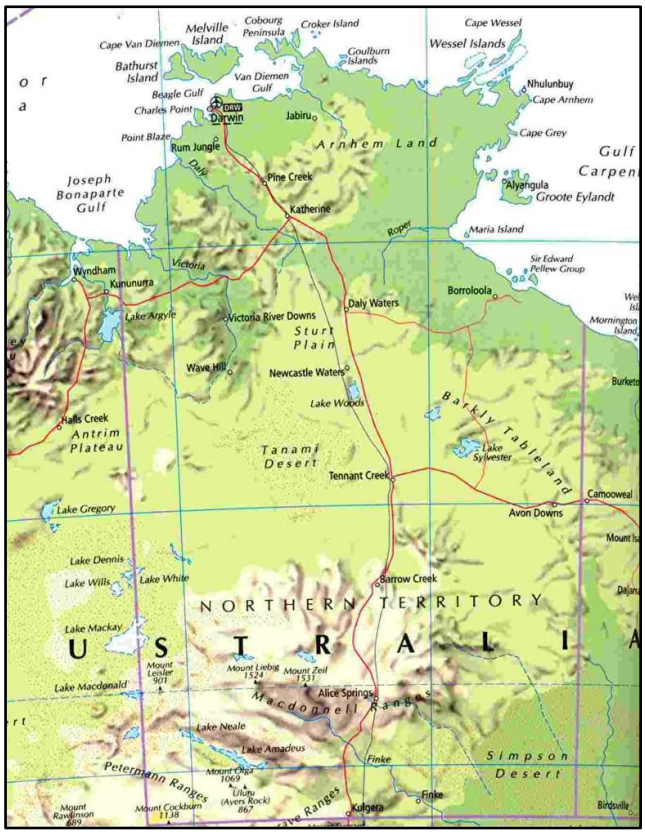
The NTML established a Steering Committee to provide oversight of the Needs Assessment. At the Steering Committee's first meeting on 14 December 2012, it was agreed that a Sub Committee would be formed to provide governance and direction on the priority-setting process for the After Hours Project.

The Sub-Committee's membership was drawn from existing members of the Steering Committee, with additional members identified from the private sector.

Refer to Appendix N for further information on the Project Sub-Committee.

Chapter 1 – Northern Territory Profile

Profiling: Developing an overview of the region's characteristics



The Northern Territory Medicare Local's (NTML) catchment incorporates the entire Northern Territory (NT), an area covering 1,349,129 square kilometres[4] with a population of just over 233,300.[5] Despite this small population size, the NT incorporates many distinct cultural and language groups, and the differences in locality and population are significant. As such, the need for place-based planning and focus on regional differences is extremely important when considering service delivery.

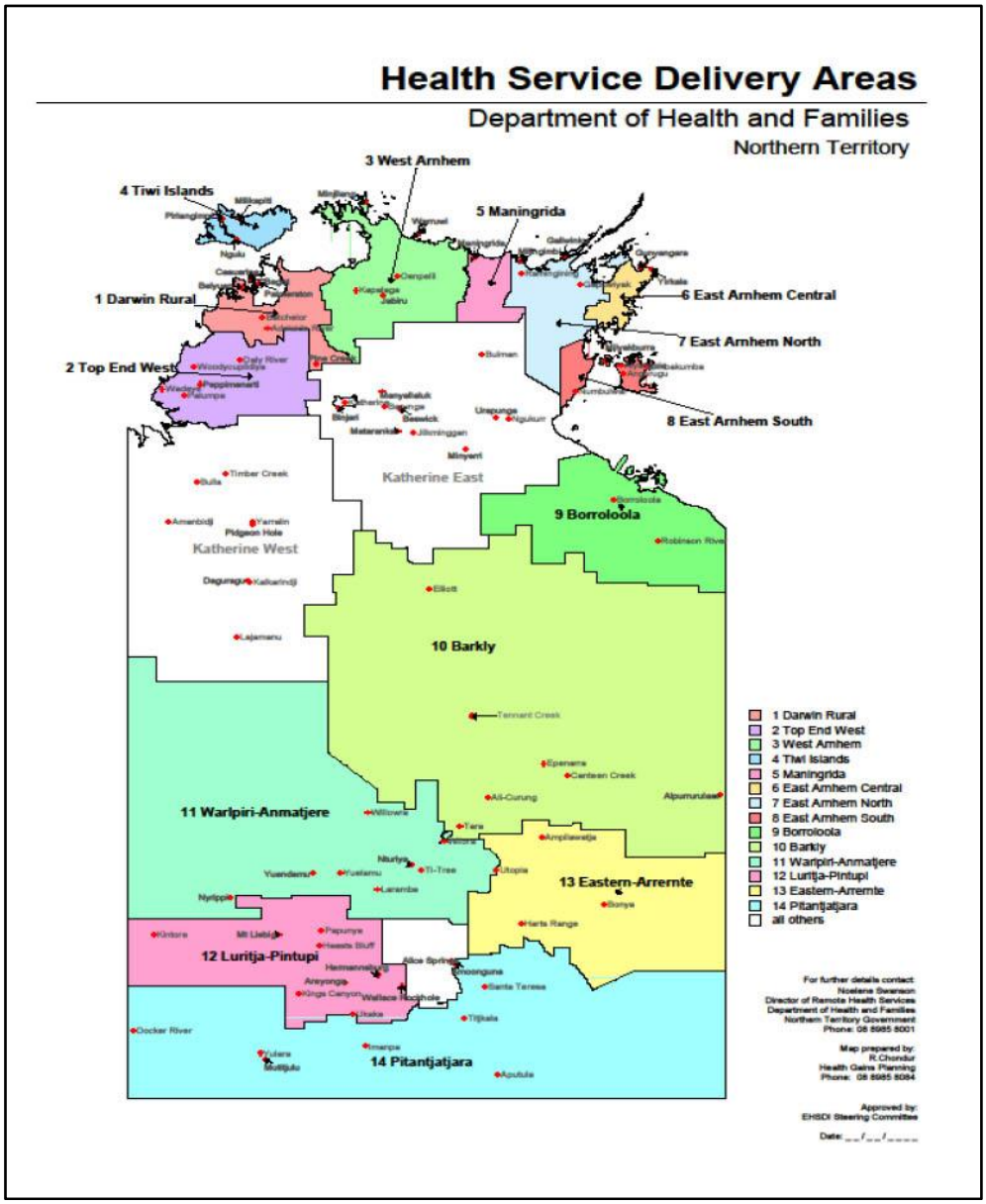
Accordingly, for the purpose of this needs assessment report, the following regional locations have been utilised when referring to data and identified needs. These incorporate Health Service Delivery Areas adopted by the NT Department of Health (see Figure 1). These are:

- Darwin Urban;
- Darwin Rural (incorporating Top End West and Tiwi Islands);

[4] Extracted from: http://en.wikipedia.org/wiki/Northern_territory
[5] Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, March 2012

- East Arnhem (incorporating West Arnhem, Maningrida East Arnhem Central, East Arnhem North and East Arnhem South);
- Katherine (incorporating Katherine West, Katherine East and Borroloola);
- Barkly;
- Alice Springs Rural (incorporating Warlpiri-Anmatjere, Luritja-Pintupi, Eastern-Arrernte and Pitantjatjara); and
- Alice Springs Urban

FIGURE 1: NT DEPARTMENT OF HEALTH, HEALTH SERVICE DELIVERY AREAS, 2010



1.1 Overview of the characteristics and health status of the Northern Territory population

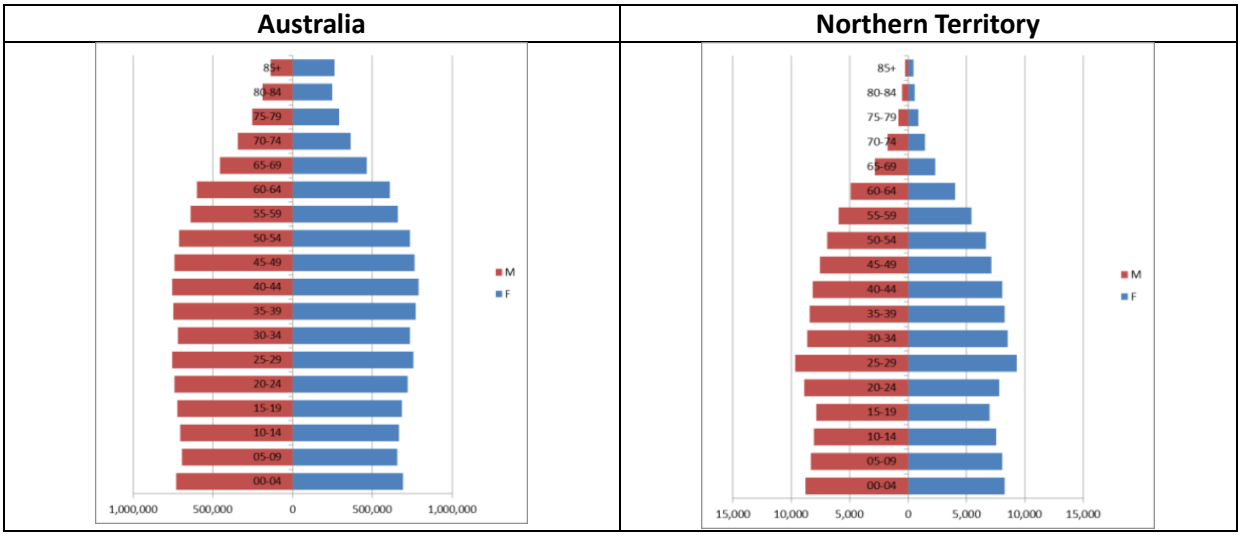
1.1.1 General Demographics

The NT is the least populous of Australia's eight states and territories (excluding external territories), with a population density of 0.17 people per square kilometre.

Sharing borders with Western Australia, Queensland and South Australia, the NT is often referred to as "the gateway to Asia" and has a vibrant multi-cultural population. The NT's population is young and highly transient. This is largely due to the workforce, with a strong mining and defence presence, and a highly mobile Indigenous population.

Approximately 48.3% of the NT population is female, 51.7% male, and with an overall Indigenous population of 30%.[6] The NT has a much younger population in comparison with the rest of Australia, with a much larger population of people in the 20-34 age brackets when compared with Australian rates.

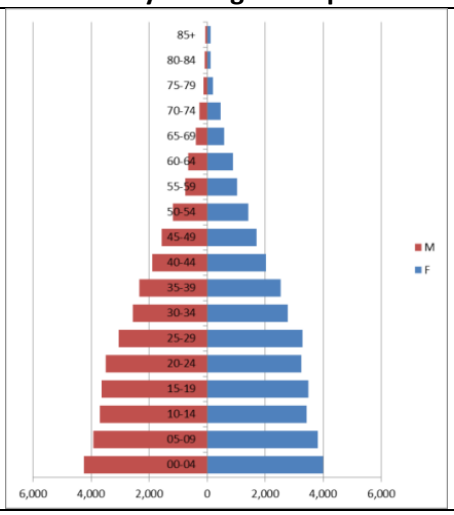
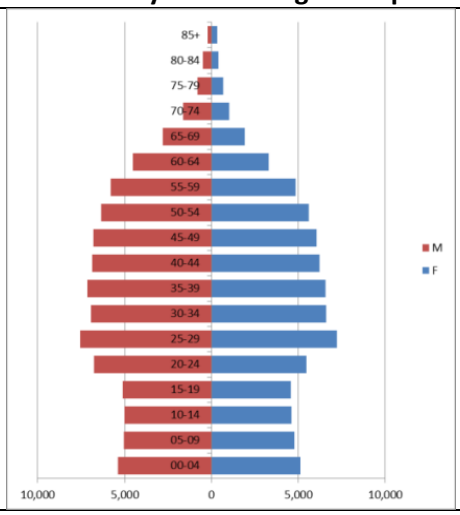
FIGURE 2: POPULATION PYRAMIDS, NORTHERN TERRITORY AND AUSTRALIA



The NT's Aboriginal population is significantly younger when compared to the rest of the NT, reflective of Indigenous people's reduced life expectancy rates.

[6] Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, March 2012

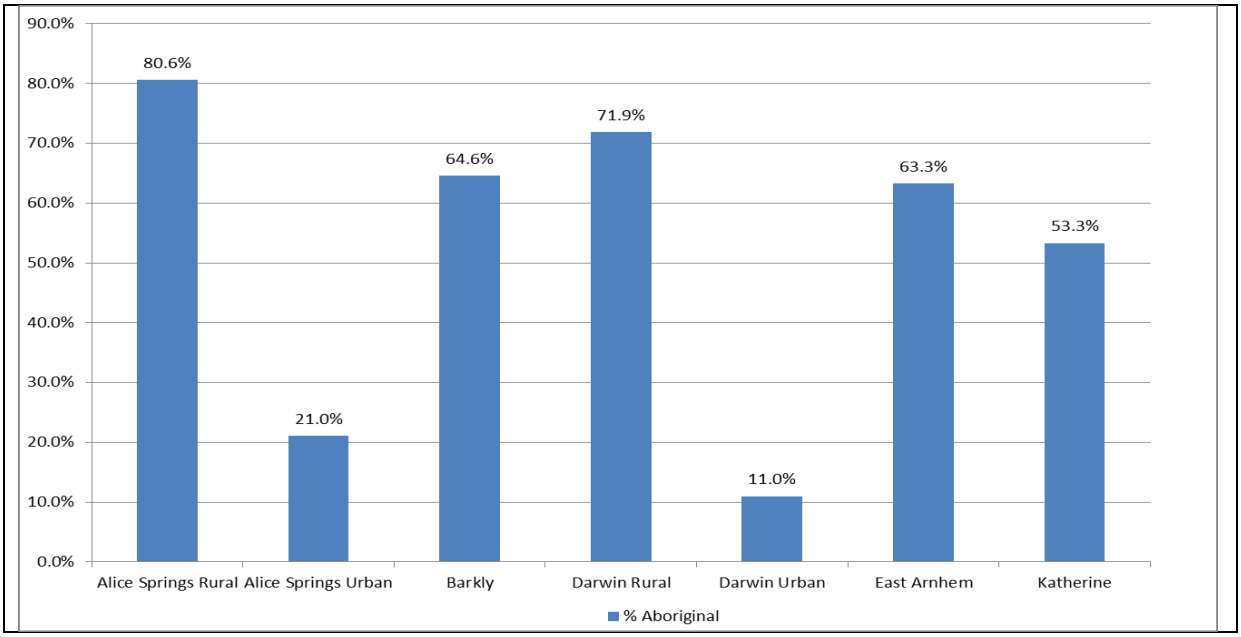
FIGURE 3: POPULATION PYRAMIDS, NORTHERN TERRITORY, ABORIGINAL AND NON-ABORIGINAL POPULATIONS

Northern Territory Aboriginal Population	Northern Territory Non-Aboriginal Population
	

Approximately 30% of the NT's population identified as being Indigenous in the 2011 Census, with this ranging from 80.6% of people in the Alice Spring Rural region to 53.3% in the Katherine region. On a sub-regional basis, people identifying as Indigenous may range from 97.45% of the population in Amoonguna, to 18.99% in Jabiru. (Refer Appendix C)

These key demographic issues drive need and demand on health care services, as well as influencing how, what and where services are located.

FIGURE 4: PROPORTION OF THE POPULATION WHO IDENTIFIED AS INDIGENOUS, NORTHERN TERRITORY BY REGION[7]



1.1.2 Key Population Centres

The main population centres in the NT are Darwin (estimated population 129,062[8]), Palmerston (estimated population 23,614[9]) and Alice Springs (estimated population 25,186[10]).

Regional centres include Katherine (estimated population 5,849[11]), Nhulunbuy (estimated population 4,940[12]) and Tennant Creek (estimated population 3,062[13]).

Major Remote Towns (known previously as Growth Towns) are being developed as key regional hubs, with a variety of services being available for residents, including people living on nearby outstations and homelands.[14] Major Remote Towns will be developed through a combination of targeted private and Government investment. The Major Remote Towns are:

- Ali Curung;
- Angurugu;
- Borroloola;

[7] Australian Bureau of Statistics, Census 2011
[8] Australian Bureau of Statistics, Census 2011
[9] Australian Bureau of Statistics, Census 2006
[10] Australian Bureau of Statistics, Census 2011
[11] Australian Bureau of Statistics, Census 2006
[12] Ibid
[13] Australian Bureau of Statistics, Census 2011
[14] Northern Territory Department of Regional Development and Indigenous Advancement, *Major Remote Towns – Update 2012*, 2012

- Daguragu/Kalkarindji;
- Elliott;
- Galiwinku;
- Gapuwiyak;
- Gunbalanya (Oenpelli);
- Lajamanu;
- Maningrida;
- Milingimbi;
- Ngukkur;
- Ntaria;
- Numbulwar;
- Papunya;
- Ramingining;
- Umbakumba;
- Wadeye;
- Wurrumiyanga (Nguiu);
- Yirrkala; and
- Yuendumu

There are also a number of smaller communities across the NT, supported by these larger centres, together with outstations and homelands. The population of these communities may vary from a dozen people to several hundred.

Pastoralist and farming stations are located across the NT, with populations ranging from several family members to much larger workforce groups. These may have a variety of infrastructure and worker skill-sets (e.g. some stations may have qualified nurses for their workforce).

The NT has a highly mobile population; with the 2011 Census indicating that over 20% of Territorians lived at a different address one year ago, and nearly 50% of Territorians living at a different address five years ago. As demonstrated in the below Table, these figures were higher for people residing in urban areas.[15]

TABLE 1: POPULATION MOBILITY - AUSTRALIA AND NORTHERN TERRITORY[16]

	Different address one year ago	Different address five years ago
Australia	15.9%	41.7%
NT	20.7%	46.9%
Alice Springs Rural	14.0%	26.0%
Alice Springs Urban	24.3%	54.2%

[15] Australian Bureau of Statistics, Census 2011
[16] Ibid

	Different address one year ago	Different address five years ago
Barkly	15.0%	30.7%
Darwin Rural	12.9%	28.2%
Darwin Urban	23.3%	54.0%
East Arnhem	14.1%	30.7%
Katherine	16.2%	35.5%

The NT has a highly transient workforce due to the mining, defence and tourism/hospitality sector. Indigenous people may also be transient due to cultural reasons, and for ease of access to services in urban centres.

1.1.3 Social Determinants of Health

The social determinants of health are factors affecting a person's life, which may also affect their health. If a person feels safe, has a job that earns sufficient money, and feels connected to their family and friends, they will generally be healthier. Social determinants of health can include whether a person[17]:

- is working;
- has a good education;
- has enough money;
- whether they feel safe in their community; and
- whether they feel connected to friends and family.

Social determinants which may be especially important to Indigenous people can include:

- their connection to land; and
- a historical past that took people from their traditional lands and away from their families.

- Employment

Unemployment is known to be detrimental to health, and can have significant impacts on both physical and mental health, with unemployed people experiencing more serious chronic illness, greater prevalence of disability, and suffer more psychological illness, stress and anxiety.[18] A study undertaken by Queensland Health in 2002 found people who were unemployed were 70% less likely to rate their health status as good, very good or excellent. People who were unemployed were also

[17] Australian Indigenous Health Info Net, *Summary of Australian Indigenous Health,* extracted at: http://www.healthinfonet.ecu.edu.au/health-facts/summary

[18] Mathers, C D and Schofield, DJ, *The Health Consequences of Unemployment: The Evidence*, Medical Journal of Australia, 1998 quoted in *Social Determinants of Health: Unemployment Fact Sheet*, Southern Public Health Unit Network, Queensland Health

30% less likely to exhibit good health behaviours in relation to physical activity, good nutrition and smoking rates.[19]

The overall NT employment rate is comparable to the rest of Australia; however, unemployment rates in more regional areas such as Alice Springs Rural, Barkly and Darwin Rural are equivalent to double the national average.

TABLE 2: EMPLOYMENT STATUS, NORTHERN TERRITORY AND AUSTRALIA[20]

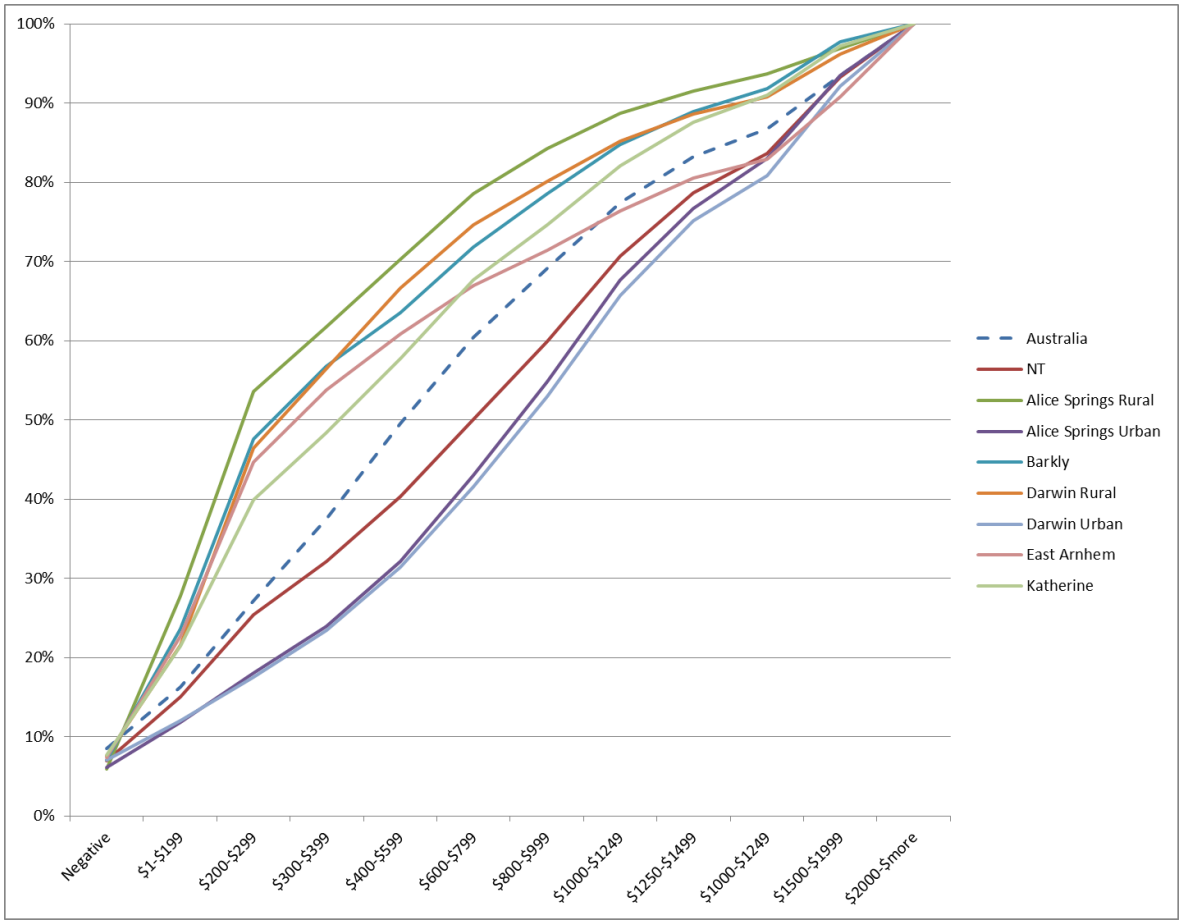
	Labour Force Participation	Unemployment Rate
Australia	61%	6%
NT	64%	5%
Alice Springs Rural	43%	13%
Alice Springs Urban	69%	3%
Barkly	45%	11%
Darwin Rural	53%	11%
Darwin Urban	69%	4%
East Arnhem	56%	10%
Katherine	57%	11%

- Income

The link between poverty and health is clear and the financially worst-off generally experience the highest rates of illness and premature death.[21] Access to health services, including being able to visit a Doctor or to purchase essential medication, or even the ability to purchase high quality nutritious food is inhibited for people from a lower socio-economic status.

[19] *Social Determinants of Health: Unemployment Fact Sheet*, Southern Public Health Unit Network, Queensland Health
[20] Australian Bureau of Statistics, 2901.0 - Census Dictionary, 2011, 2012
[21] Queensland Health, *Social Determinants of Health: Public Health Services Role*, Queensland Health 2002, quoted in *Social Determinants of Health: Income Fact Sheet*, Southern Public Health Unit Network, Queensland Health

FIGURE 5: PROPORTION OF THE POPULATION WHO REPORTED PERSONAL INCOMES, BY INCOME BAND AND REGION, NORTHERN TERRITORY[22]



It is noted that the income distributions for the NT, Darwin Urban and Alice Springs Urban are all higher than the national average. Higher reported incomes in East Arnhem are likely associated with a relatively small number of people (the majority non-Indigenous) who reported high earnings. This is consistent with the presence of a large mining and refining operation within that region, and is not reflected in better health outcomes for Indigenous residents in these areas.

- Education

Generally, people with the poorest health status have the lowest education levels. People with lowered education levels may be more vulnerable to unemployment, and consequent lower overall socio-economic status. The situation can be compounded by lower health literacy levels, making it more difficult for people to learn and adopt healthier habits.[23]

[22] Australian Bureau of Statistics, Census 2011
[23] Quoted in *Social Determinants of Health: Education Fact Sheet*, Southern Public Health Unit Network, Queensland Health

Education levels and participation rates vary across the NT, with declining rates of enrolment by Indigenous students in secondary education in the NT. In the NT in 2011, 81% of Indigenous students enrolled in Year 3 participated in the *National Assessment Program: Literacy and Numeracy* (NAPLAN) tests, dropping to 70% for enrolled Year 9 students.[24] Whilst NAPLAN results are not indicative of broader learning outcomes and overall education levels, it does indicate a reduced participation by Indigenous students in the mainstream education system, with resultant impacts on further education, skilled employment opportunities and income levels.

TABLE 3: HIGHEST NON-SCHOOL QUALIFICATION OBTAINED - NORTHERN TERRITORY AND AUSTRALIA[25]

	Post Graduate Qualifications %	Bachelor's Degree %	Certificate/Diploma %	Total %
Australia	5.3	13.5	26.1	44.9
NT	4.4	10.4	25.4	40.2
Alice Springs Rural	1.8	4.8	13.9	20.5
Alice Springs Urban	6.1	13.0	27.0	46.2
Barkly	2.1	5.3	14.0	21.4
Darwin Rural	2.2	5.5	19.5	27.1
Darwin Urban	5.1	12.1	28.0	45.3
East Arnhem	3.2	6.7	20.9	30.8
Katherine	2.1	6.2	22.5	30.8

1.1.4 Proximal determinants of health

- Service Utilisation

The recently published *National Health Performance Authority 2013, Healthy Communities: Australian's Experiences with Primary Health Care in 2010-2011* report indicated that in the NT, 87% of adults surveyed rated their health as excellent, very good or good.[26] Seventy-eight percent of adults had seen a General Practitioner in the previous year, with an average of 2.9 visits per adult per year. This compares to 3.5 visits per adult per year in other Medicare Locals within the "Rural 2" classification.[27]

[24] Hughes, Helen, *Indigenous Education 2012*, The Centre for Independent Studies, 2012
[25] Social Health Atlas of Australia, *Northern Territory Data by Local Government Area*, 2013
[26] National Health Performance Authority, *Healthy Communities: Australian's experiences with primary health care in 2010–11,* 2013
[27] Namely Central and North West Queensland, Far North Queensland, Goldfields-Midwest (WA) and Kimberley-Pilbara (WA)

The average number of GP attendances after hours per adult per year was 0.11 visits, compared to the average of 0.17 per adult per year in the "Rural 2" classification.[28]

This report also provided an indication of consumer perspective on General Practice services, with 18% of Territory respondents believing they had waited too long to get an appointment with a GP, and 16% reporting there were cost barriers associated with seeing a GP[29].

This last finding is consistent with *Social Health Atlas of Australia* data, which reported that in the NT in 2010, 22,646 adults (16,248 in Darwin alone) had delayed undergoing a medical consultation because they could not afford it (modelled estimate).[30] Additionally, 17,319 adults (11,955 in Darwin alone) had delayed purchasing prescribed medication because they could not afford it (modelled estimate).[31]

TABLE 4: UTILISATION OF GP SERVICES - NORTHERN TERRITORY – 2009/10[32]

	Number of services used	Rate per 100,000 population	Ratio to Australian rate
Australia	119,478,018	539,598.0	-
Northern Territory	647,520	320,221.3	59%
Darwin	423,699	376,005.5	70%
Non-Metropolitan NT	216,092	248,061.5	46%

If rates of General Practitioner service utilisation in the NT were at the same level as those for the rest of Australia, an additional 443,602 GP services would have been used in 2009/10.

- Under-Claiming of Medicare and Pharmaceutical Benefits

Whilst Medicare Benefits and Pharmaceutical Benefits payment rates have increased over time in the NT, the NT population does not utilise these schemes to the same extent as the rest of Australia.

On a per capita basis, a Territorian uses six Medicare services per year (total value in 2003/04 being $222); the national average is 11 services per year (total value in 2003/04 being $427).[33] Pharmaceutical benefits are similarly under-utilised, with a Territorian using three services per year

[28] National Health Performance Authority, *Healthy Communities: Australian's experiences with primary health care in 2010–11,* 2013
[29] Ibid
[30] Social Health Atlas of Australia, *Northern Territory Data by Local Government Area*, 2013
[31] Ibid
[32] Public Health Information Data Unit, Social Health Atlas of Australia, *Northern Territory Data by Local Government Area*, 2013
[33] The MBS shortfall for the NT estimated to be $23.1 M in 2003/04 (an increase from $15.8 M over the previous 10 years), with the shortfall in the PBS $25.8 M in 2003/04

(total value in 2003/04 being $87) compared to the national average of nine services (total value in 2003/04 being $233).[34]

This has resulted in significant funding shortfalls to the NT, for both Medicare and Pharmaceutical Benefits. It is noted that substantial other funding is provided to the NT for specific programs associated with Indigenous health, but there remains significant shortfall, with consequent impacts on the type and availability of health services in the NT.

1.1.5 Other Risk factors

Selected other health risk factors for the NT population include smoking rates and vaccination coverage. The NT has nearly double the average number of women who smoke during pregnancy when compared with the rest of Australia (27.3% to 15%)[35], with rates being much higher in regional and remote areas. Childhood vaccination rates are comparable to the rest of Australia, with many remote health centres conducting immunisation programs.[36]

The NT also has nearly double the national rate of children assessed as developmentally vulnerable against the Australian Early Development Index domains. These figures are nearly tripled in more remote areas, such as Alice Springs Rural. (Refer Appendix E)

1.2 Local factors affecting health

Within the NT, there are unique local differences which may influence people's health, and how and when they access health services. These range from the type and variety of service available in each area, to infrastructure issues.

In urban areas, most primary health care services are provided by GPs, with some services provided by Nurses, either through General Practices or in Community Health Centres. Aboriginal Health Practitioners (formerly known as Aboriginal Health Workers) play an important role in the delivery of primary health care services in both urban and remote settings.

The primary health care system in remote areas is not based on a GP and Medicare-based fee-for-service funding model. In remote areas, significant proportions of primary health care services are provided by Nurses, Aboriginal Health Practitioners and allied health professionals, whose services are generally non-Medicare refundable. Other comprehensive primary health care services, particularly population health and promotion services are not refundable under Medicare. Even where Medicare services are claimable, the actual costs of delivering services in a remote area are much higher than in urban or rural settings and the refunded benefit does not reflect the actual cost of service delivery.

[34] Byron P, Zhao Y, Guthridge SL, Brailsford R, Stacey F, Parkinson J. *Medicare and Pharmaceutical Benefits Scheme Usage Patterns in the Northern Territory 1993/94 to 2003/04*, Northern Territory Department of Health, Health Gains Unit, 2005
[35] Refer Appendix F
[36] Refer Appendix G

Doctors are located in some larger remote communities, but most operate on a fly-in, fly-out model, as do specialists and other allied health providers. Many patients are required to travel to hospitals to undergo assessments and receive treatment due to a lack of facilities in communities.

Key factors affecting health in the NT include:

- *Population Mobility*

The Indigenous population is highly mobile, with complex inter-linked kinship and landownership, and frequent movement between communities occurs to maintain family connections and take part in ceremonies.

As major service centres, Darwin and Alice Springs also experience population mobility due to workforce issues and tourism.

- *Substance addiction and misuse (including alcohol, illicit drugs, petrol sniffing and other inhalants)*

Substance misuse, including alcohol, petrol and other illicit drugs, is a huge health concern and cost across the NT. Night patrol services (and a day patrol service in Darwin37) operate in 80 communities across the in the NT38. In addition to Night Patrol Services, there are 18 publicly funded treatment agencies in the NT, who provided 3,587 treatments in 2010-11, with 64% of clients receiving treatment for alcohol use.39 Residential rehabilitation facilities, including those specifically for Aboriginal people and their families, are available in both urban and regional centres. Short term Sobering up Shelters have also been established in some urban and regional centres.

- *Mental Health and Clinical/Support Services*

Mental health services (both in-hospital and outreach services) are available in Darwin and Alice Springs, through the Department of Health. Other NGO and many ACCHO have mental health support programs. Regional centres and smaller communities may receive visiting mental health services, with each community receiving on average a visit by a case manager every four weeks and a Registrar or Consultant visit every three months. Limited Child and Adolescent overnight visits are provided in certain areas.

The management and evacuation of patients suffering from mental health issues, including psychotic episodes, can be particularly challenging for staff at remote health centres, with the Remote Health Atlas and Central Australian Rural Practitioners Association (CARPA) Manual providing guidance.

[37] The two Darwin based services will cease operation as of 1 July 2013, with these services to be provided by the Northern Territory Police. http://www.abc.net.au/local/stories/2012/12/06/3648959.htm
[38] Department of the Attorney-General, *Night Patrol Services in the Northern Territory: Operational Framework*, Australian Government, 2010
[39] Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2010-11: state and territory findings*, 2013

- *Aged and Disability Care Services*

The Department of Health provides coordination for Aged and Disability Care Teams, partnering with the Australian government, local councils, advocates and private providers to provide services for adults and children. The Department provides and funds services such as "assessment and therapy, case management, respite, supported accommodation and care, community access, information and training, licensing and standards, equipment and subsidies, monitoring and evaluation and guardianship."[40] Private and public aged care facilities are available across the NT.

- *Poor Health Outcomes for Indigenous People*

The health status of Indigenous people in the NT is worse than non-Indigenous Territorians against most indicators, with non-Indigenous Australians living on average 20 years longer than Aboriginal Australians. Indigenous Territorians suffer from higher levels of renal disease, pneumonia and other respiratory conditions, are much likely to be of lower birth weight, and suffer from preventable eye disease.[41]

Indigenous people are hospitalised at over six times the rate of other people in the NT, with the greatest differences in hospitalisation rates being for endocrine, metabolic and nutritional disorders, for which Indigenous Australians were hospitalised at around five times the rate of other people.[42] In addition, Indigenous Australians in the Northern Territory were hospitalised at over four times the rate of other people for respiratory diseases, and infectious and parasitic diseases.[43] Aboriginal people in the NT were hospitalised for rheumatic heart disease at 14 times the rate of other Australians.[44]

The incidence rate of end-stage renal disease for Indigenous Australians in the NT was 26 times the rate of non-Indigenous Australians in 2006–2008 (188 and 7 per 100,000 people respectively)[45]. Self-managed dialysis chairs are available at a range of smaller health centres and regional hospitals, e.g. Gove District Hospital and the Tiwi Dialysis Unit at Wurrumiyanga, for clients who can dialyze independently.

- *Monsoonal weather*

Travel between communities can be severely limited by weather and seasonal issues such as heavy rainfall, localized flooding, cyclones and storms which cut road access in the wet season (October to May). Most roads are dry season use only, and many are four wheel drive use only. Island communities are often entirely reliant on barge transport for groceries and other items.

[40] http://www.health.nt.gov.au/Aged_and_Disability/
[41] http://www.healthinfonet.ecu.edu.au/
[42] Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework 2010 report: Northern Territory*, 2011
[43] Ibid
[44] Ibid
[45] Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework 2010 report: Northern Territory*, 2011

- *Transport issues/Distances*

Many communities are only accessible by the air, including several populous island communities with limited (if any, ferry service). This includes large regional centres such as Nhulunbuy, with the only access by road being via a 700 km gravel track.

Many remote communities, including outstations and homelands have airstrips, but some are not sealed and have no lights for night use. Maintenance of local airstrips generally comes within the remit of Shire Councils; however, if the airstrip is unlit at night, and an evacuation is required, it may be the responsibility of health centre staff to light the runway and/or clear it of any wildlife.[46]

The NT Department of Health provides support for transport costs via the Patient Assistance Travel Scheme (PATS), which provides a co-payment for NT residents to "access a range of essential specialist medical/surgical services where services are not available locally or from a visiting service."[47] Patients will receive some costs towards their travel and accommodation they are required to travel more than 200 kilometres.[48] PATS does not provide support for emergency evacuations (that is through Careflight or the Royal Flying Doctor Service) or for routine health screening. As such, the cost of routine health screening (e.g. Mammograms) is high, and uptake low.

- *Telecommunications*

In many remote areas, there is minimal telecommunication infrastructure and satellite phones may be required. In places without this infrastructure, emergency responses to critical medical issues can be delayed, and patients may be unable to access ambulance and evacuation services.

The lack of universal telecommunication coverage may also result in barriers for people residing in very remote communities to access services such as Health Direct Australia after hours telephone help line. Such difficulties in accessing can be compounded for patients speaking English as a third or fourth language.

- *Staff Accommodation*

The lack of availability of staff accommodation is a major issuing in regional centres and remote communities. This can hamper the expansion of health and other services, and can result on over-reliance of a "Fly-in, Fly out" workforce.

Health staff housing in remote communities is limited and there is insufficient housing for the Indigenous residents, so it is difficult to obtain vacant housing for additional health staff. This has consequent impacts on recruitment and retention. Visitor accommodation exists in most major communities however it is also limited and inappropriate for medium to long term stays. In regional

[46] Department of Health Remote Health Atlas, http://www.health.nt.gov.au/Remote_Health_Atlas/index.aspx
[47] Northern Territory Department of Health, *Patient Assistance Travel Scheme Brochure,* Northern Territory Government 2008
[48] Ibid

centres, accommodation may be available but extremely expensive. For example, Nhulunbuy is a closed lease and average rental is up to $1,000 per week for a modest two or three bedroom house.

Refer Appendix J for a regional break-down on these issues.

1.3 Impact of the Northern Territory's characteristics on after hours needs

1.3.1 Urban Areas

The characteristics of a large urbanised population, with generally high employment levels result in different expectations from the primary health care service. Many providers (in private practice) indicated their belief that patients utilised an after hours service largely as a convenience around their working hours and schedules. Several providers (in private practice, who currently and previously delivered after hours services) also noted that the after hours service was often busiest between 6 pm and 8 pm. Patients in this time included people finishing work and parent's collecting children from after school activities or child-care and being made aware that the child needed medical attention.

There are limited exclusively bulk-billing services in Darwin and Alice Springs, however most private practitioners indicated that they will bulk-bill certain patient groups (e.g. children under 16 years, those on a Health Care Card) with some practices bulk-billing up to 55% of patients.

Darwin and Alice Springs are considered Areas of Workforce Shortage, and difficulties are experienced in the recruitment and retention of staff, both Doctors and Nurses. It was considered particularly difficult to recruit staff to work in the after hours period, with concerns being expressed over "work – life" balance and staff burn-out.

A limited number of private practitioners provide a formal "on-call" service, with only one service in Alice Springs indicating that they would do clinic meet-ups after hours. Other services indicated they would triage the patient over the telephone and either refer to the local Emergency Department or to an appropriate service during standard hours.

Many private practitioners, together with Danila Dilba and the Central Australian Aboriginal Congress (Congress), indicated that Doctors conduct informal on-call work, including home visits and after hours work, for palliative care patients, long-term patients, and patients in aged care facilities.

Of the two urban ACCHO, Congress currently offers after hours services, with Danila Dilba considering this as part of their longer term plans. The view was expressed during consultations that Aboriginal people may be more familiar in seeking after hours services from a hospital Emergency Department rather than a more mainstream General Practice, but this has yet to be tested with consumers.

1.3.2 Regional Areas

The regional centres of Katherine, Tennant Creek and Nhulunbuy experience a range of issues similar to those experienced in both urban and remote areas.

Workforce recruitment and retention was raised as a significant issue in consultations undertaken in these areas. Suitable accommodation for staff was considered a particular issue in recruiting and retaining staff, with Anyinginyi Aboriginal Health Corporation (Anyinginyi) in Tennant Creek recently building six private accommodation units for Doctors and Dentists. It was reported that this had contributed to successful recruitment for these positions. The service is considering expanding this to developing more accommodation for its Indigenous workforce, with the idea to attract and maintain a stable workforce pool.

Regional centres also have smaller workforce pools to draw upon, particularly in delivering after hours services. It was indicated during consultations that not having to work after hours was often a key incentive in attracting staff to work in regional centres, which cannot otherwise compete with other areas in terms of salary etc. Having smaller workforces may also mean that delivering after hours services can have more pronounced effects on staff, in terms of burn-out.

In Katherine, one of the GPs provides on-call work through the Katherine Hospital for obstetrics and anaesthetics services, and may experience limitations in conducting after hours through their General Practice. Similarly, in Tennant Creek, for the current GP service, operated by the Royal Flying Doctor Service (RFDS) to conduct after hours would have significant impacts, and costs, on their service and personnel.

In the regional centres, none of the ACCHO providing services to the regional centres (Miwatj Aboriginal Health Corporation in Nhulunbuy, Wurli Wurlinjang Health Service in Katherine and Anyinginyi Health Aboriginal Corporation in Tennant Creek) provides a separate after hours services.[49]

The private GP service offering after hours in Katherine (Katherine After Hours Service through Gorge Health) indicated that a small percentage of patients for this service were usual patients of Wurli Wurlinjang, but many Aboriginal patients seeking after hours services in regional centres are referred to the local hospital. The three ACCHO servicing the regional centres (Wurli Wurlinjang in Katherine, Anyinginyi in Tennant Creek and Miwatj in Nhulunbuy) advised that they have formal agreements with the local hospital for this purpose.

Where centres are serviced by a hospital, this service was generally considered by providers to be largely sufficient to meet after hours demand (including both acute matters and GP type attendances). This may be due to historical factors, as in Tennant Creek for example, Anyinginyi does not provide after hours services, and the town was without another GP service for approximately two prior to RFDS commencing in 2007. The RFDS service was established in Tennant Creek due to community and council demand.

[49] Anyinginyi provides home visits after hours on an on-call basis to the local aged care facility, four nights per week

Access to diagnostic equipment and specialist services was an issue in service delivery in regional centres. Whilst this may relate to more standard hours services, it can have a resultant impact on after hours needs and resources, should patient's conditions deteriorate. Katherine Hospital indicated that they are looking to further explore the use of telemedicine and other new technologies (such as portable equipment e.g. ultrasounds) to maximise the number of patients treated in their home community or at their nearest regional centre.

The medical imaging service in Katherine has recently installed a CT machine, which is providing a bulk-billing service however there is a lack of other services in regional centres, including the capacity to undergo routine health screening tests and blood banks.

The Director of Medical Services at the Katherine Hospital indicated that he was aware of patients (in the Katherine region) who were evacuated to the Royal Darwin Hospital when the Katherine Hospital had appropriate facilities (i.e. surgical facilities) to manage them, and transversely, patients being evacuated to the Katherine Hospital when only the Royal Darwin Hospital had the appropriate facilities. This may result in delay to patients, and costs spent on inappropriate evacuations. Improved communication between services on their capacity and capabilities was seen as helping to overcome this issue.

1.3.3 Remote Areas

Access to services is a key issue for remote areas, particularly relating to the delivery of after hours services. Due to the remote locations and transport infrastructure, many smaller communities are inaccessible at night, except by unsealed roads, and many are accessible only by air in the wet season (October to May).

Most remote heath centres (both Department of Health and ACCHO) operate after hours on call rosters through the local health staff and supported by Remote Medical Practitioners (RMPs) (formerly known as District Medical Officers) based in Darwin, Nhulunbuy and Alice Springs. Patients generally contact the staff on-call through a special phone at the health centre or through the usual number being diverted.

Some RMPs provide their services from overseas, which may occasionally contribute to communication difficulties due to a lack of local knowledge of conditions, and when possibly combined with an agency-based nurse who may also be unfamiliar with local conditions. Whilst the on-call system provides good coverage to patients, it may result in staff on-call acting as a liaison between a patient, their family and the RMP to ascertain the nature and extent of the patient's condition and whether any retrieval is required.

With limited resources after hours on-call work has a detrimental impact on day services with staff requiring a rest period break in between shifts. On-call work having an effect on standard hours services was raised as a significant factor for several remote providers (as well as regional and urban providers).

Health education programs (e.g. anti-smoking programs, diabetes screening, immunisations) are delivered during standard hours, and if staff are not available during the day to deliver such programs

(due to seeing patient's on-call at night) there may be consequent longer-term impacts on overall health. One ACCHO in the Katherine region indicated that if visiting specialists have been booked to visit a community, lack of availability of staff to coordinate patients for these visits (due to being on-call at night) results in those patients not being seen, with potential detrimental effects on their health, plus wasted costs for that service in having the specialist there.

The "appropriate" use of after hours services in remote areas was raised by several remote service providers as having an impact on service delivery. This may range from requests for non-prescription medication to one remote provider indicating that their on-call service received calls about the weather or opening hours of the local shop, as it was known someone would always answer calls received on the clinic's telephone number.

Whilst this may relate to cultural issues and the concept of standard business hours, it is important that services are available for the community during the times they are best able to access them. One remote service provider spoke of a pilot previously conducted at the Wadeye Health Centre where staff worked on a "split-shift" with the clinic being staffed from 9 am to 9 pm. This provided good coverage to the community and resulted in less call-outs after hours; however it was stopped following a change in management.

Remote Health Centres (whether Department of Health or ACCHO) are not equipped to manage patients for 24 hours (or longer), and where evacuations have been delayed, this has required staff to work round-the-clock, with resultant flow-on effects to standard hours services. The complex health needs of the population, including high incidences of chronic disease was also considered to have increased demands on after hours services.

Limited access to diagnostic equipment was also considered an issue in patient management, with the Director of Medical Services at the Gove District Hospital indicating that approximately 25% of patients using the PATS scheme due to requiring x-rays not available in their home community.

Chapter 2 - Service Capacity Mapping

Developing an understanding of the current access to, and availability of, after hours health services in the Northern Territory

For the purpose of the National Health Reform, the after hours period is defined as:

- Before 8:00 am and after 6:00 pm on weekdays;
- Before 8:00 am and after 12 noon on Saturday; and
- All day Sunday and Public Holidays

Many providers in private General Practice interviewed noted the disparity between the above definition and the definition of after hours services under the Medicare Benefits Schedule, which defines after hours services from 8 pm on weekdays and after 1 pm on Saturdays.

It should also be noted that there is a distinction between the provision of *emergency medical care* after hours and the General Practice-type attendance for minor acute health matters. Consultations with providers focused on the latter, with providers acknowledging the importance of maintaining and providing services after hours for emergency medical care in the appropriate facilities e.g. Hospitals.

2.1 Availability and scope of current health services

2.1.1 After Hours Service Models

Health services in the NT are delivered by a mix of Government services, private practices, ACCHO and other Non-Government Organisations. Privately owned and operated services are more common in urban and regional areas, with core remote health services largely delivered by NT Government clinics or by ACCHO.

Refer to Appendix A for a summary of available health care services, including primary health care, hospitals and allied health services in the after hours period.

Current after hours health service providers in the NT can be classified into nine broad service models:

1. Extended Hours GP Practice - fee for service or bulk-billing;
2. Super Clinic;
3. Hospital based After Hours GP Clinic;
4. Public Hospitals – Outpatient/Emergency Department;
5. After Hours GP Helpline;
6. Remote on call services – Department of Health and Aboriginal Community Controlled Health Organisations;
7. Aboriginal Community Controlled comprehensive after hours service;

8. Urgent Care After Hours Clinic; and
9. Extended Care Para-medicine Program.

Service Model 1: Extended Hours GP Practice – fee for service of bulk-billing

Feature	Broad Profile
Location	Urban and regional centres
Number of services	Eight
Site	In a stand-alone building in a central location (i.e. suburban shopping centre)
Operating Hours	Variable, generally: Monday – Friday – open until 9 pm Saturdays, Sundays and Public Holidays – often until early afternoon
Governance	Private practices
Management of Patients	Patients managed largely on an appointment basis with some walk-in appointments reserved. Some Practices provide an after hours on-call service (including occasional home visits) for selected and long-term patients (e.g. palliative care patients). This is not generally an advertised service.
Financial	• Fee for service – fees up to $90 for after hours services • Patient receives Medicare rebate of approximately 40% • Some practices exclusively bulk-bill, other practices no routine bulk-billing • Some practices in receipt of After Hours PIP Payment – Tiers 1 – 3
Linkages with Other Services	Generally a formal or informal agreement with local hospital for patients to be accepted after hours

Service Model 2: Super Clinic

Feature	Broad Profile
Location	Palmerston
Number of services	1
Site	In a separate building within the Palmerston Health Precinct
Operating Hours	Seven days per week plus Public Holidays – 8 am to 10 pm
Governance	Managed by not for profit company FCD Health (venture between Flinders University and Charles Darwin University).
Management of Patients	Patients managed largely on an appointment basis with some walk-ins
Financial	• Fee for service – fees up to $80 for extended hours services (between 6 – 10 pm) • Patient receives Medicare rebate of approximately 40% • Super clinic model is to bulk-bill certain patient groups. Approximately 60% bulk-billed during day service and approximately 80% bulk-billed in extended hours service (6 – 10 pm) • Doctors operate from clinic on a facility fee model
Linkages with Other Services	Palmerston Urgent Care After Hours Service operates from same building between 10 pm and 8 am. Referrals made to Royal Darwin Hospital where necessary. Super Clinic also houses allied health services, and the Precinct houses other services including pathology.

Service Model 3: Hospital based After Hours GP Clinic

Feature	Broad Profile
Location	Alice Springs
Number of services	1
Site	Currently operating from Outpatients at the Alice Springs Hospital
Operating Hours	Monday – Friday – 7 – 10 pm Saturday – 4 – 7 pm Sunday and Public Holidays – 10 am – 12 noon and 5 – 7 pm
Governance	NTML receives funding for this clinic though the General Practice After Hours Grant program. Funding sub-contracted to the Alice Springs Afterhours Practitioner Cooperative. Three local GPs are Directors of the Cooperative.
Management of Patients	Patients managed on an appointment basis, with some walk-ins
Financial	• Clinic funded through a GPAH grant • Fee for service (Health Care Card holder $70, Normal consultation $90 and international patient $140) • Bulk-billing at Doctors discretion • Doctors receive 60% of consultation fees • Significant 'in-kind' support (valued at approximately $70,000) received from the Department of Health through the Alice Springs Hospital. This includes minimal rent, consumables and security
Linkages with Other Services	GPs from a range of services participate in the roster. Patients are referred to the Emergency Department at the Alice Springs Hospital for urgent care. Services within Alice Springs refer their patients to the Clinic for After Hours service.

Service Model 4: Public Hospital – Outpatient/Emergency Department

Feature	Broad Profile
Location	Urban and regional centres
Number of services	5
Site	Within hospital campus
Operating Hours	24 hours, 7 days
Governance	Currently managed through NT Department of Health but will be managed by two Independent Hospital Boards from 1 July 2013
Management of Patients	After hours patients managed on walk-in basis through the emergency department. Some self-present, others brought by ambulance.
Financial	Generally free Some fees may apply for international patients or patients choosing to be seen as private patients (not generally applicable for Emergency Department treatment)
Linkages with Other Services	Some Remote Medical Practitioners (formerly known as District Medical Officers) based in the hospitals.

Service Model 5: After Hours GP Telephone Helpline

Feature	Broad Profile

Location	National telephone help-line
Number of services	1 (Heath Direct Australia)
Site	N/A
Operating Hours	• Monday – Friday – 6 pm – 8 am • 6 pm Friday to 8 am Saturday • 12 noon Saturday to 8 am Monday • All day on public holidays
Governance	Public company limited by shares (funded by the Australian Government and Governments of Australian Capital Territory, New South Wales, Northern Territory, South Australia, Tasmania and Western Australia)
Management of Patients	Call is triaged by registered nurse. Patient referred to help-line GP if necessary who talks with the person, assesses their condition, makes a diagnosis and provides medical advice. Options for patients include self-management, wait until business hours to see usual GP or referred to nearby after hours service. Patient transferred directly to '000' if necessary.
Financial	Fully funded by. Calls are free from a land-line, but charges from mobiles may apply
Linkages with Other Services	Utilise National Health Service Directory to refer patients to their nearest available service.

Service Model 6: Remote on call services – Department of Health and Aboriginal Community Controlled Health Organisations

Feature	**Broad Profile**

Feature	Broad Profile
Location	Remote communities
Number	56 Department of Health clinics and approximately 40 clinics under the auspice of ACCHO
Site	Standalone building, centrally located
Operating Hours	Services generally open between 8 am – 5 pm with after hours services available 24 hours on-call
Governance	NT Department of Health: Clinic Manager employed who reports to an Area Service Manager within Remote Health in the Department of Health. ACCHO: Generally employ Director of Medical Services who reports to the Chief Executive Officer and/or Board. Board is independently appointed and often elected by the communities they represent.
Management of Patients	Patient contacts Nurse/Aboriginal Health Practitioner in first instance. They triage and/or liaise with local GP/Remote Medical Practitioner for further treatment and/or evacuation. After hours number often located on clinic door or clinic telephone diverted to after hours telephone carried by staff member.
Financial	Service generally free for patients. Clinics funded by Government (NT and Australian) Other programs and services (e.g. specific health prevention programs) may be funded by other external agencies
Linkages with Other Services	Strong linkages with hospitals and patient transport services (St John Ambulance) and evacuation services (Careflight and RFDS). Other links with community Night Patrol and NT Police.

Service Model 7: Aboriginal Community Controlled comprehensive after hours service

Feature	Broad Profile
Location	Alice Springs
Number of services	1 (Central Australian Aboriginal Congress)
Site	Standalone building, centrally located.
Operating Hours	• Monday to Friday - 8:30 am – 8 pm • Saturday, Sunday and Public Holidays - 8:30 am – 12 noon
Governance	Aboriginal Community Controlled Health Organisation, managed by an independent Board
	Walk-in basis with some appointments Congress provides additional services in this period, include in-house pharmacy services and a bus service to escort people to and from the clinic.
Financial	Bulk-billing service
Linkages with Other Services	Patients referred to the Alice Springs Hospital when Congress is closed

Service Model 8: Urgent Care After Hours Clinic

Feature	Broad Profile
Location	Urban centre (Palmerston)
Number of services	1
Site	Operates from the Palmerston Super Clinic premises.

Feature	Broad Profile
	Within dedicated health precinct in local suburban area
Operating Hours	10 pm to 8 am, seven days a week
Governance	Clinic operated by the NT Government, through agreements with Ochre Health (supply medical staff) and International SOS (supply nursing staff). Noted that there are separate governance arrangements between the NT Department of Health and Ochre Health, and between the NT Department of Health and International SOS, with separate service agreement contracts.
Management of Patients	Patients seen on a walk-in triaged basis
Financial	Free service Funded by the Department of Health and Ageing through the NT Government Department of Health
Linkages with Other Services	Based at the Palmerston Super Clinic (this provides services between 8 am and 10 pm). Handover occurs if any patients require management across the two handover periods.

Service Model 9: Extended Care Para-medicine Program

Note – service not yet commenced. To be piloted from mid-March 2013 to 30 June 2014

Feature	Broad Profile
Location	Greater Darwin (90 km radius of Darwin)
Number of services	1
Site	Mobile service

Feature	Broad Profile
Operating Hours	To be established. Likely to operate between 2 pm and 10 pm
Governance	Project being managed by St John Ambulance NT Darwin office. Internal project steering committee has been established. Project manager keen to establish links with GPs in the Greater Darwin region and to work with the NTML in this process.
Management of Patients	Patients contact 000 when requiring assistance. Call will be triaged in usual way and if suitable for Extended Care Para-medicine (ECP) assistance, ECP paramedic will attend at patient's location to treat. ECP paramedic operates from separate vehicle (not an ambulance) and can escalate to an ambulance if required. St John will utilise the SIREN patient records system, and are finalising ways to have this system communicate with patient's usual treating GP's e-health system.
Financial	Free service. Being funded through Health Workforce Australia.
Linkages with Other Services	Royal Darwin Hospital. Hoping to develop relationships with GPs (to be able to refer patients to) via NTML

2.1.2 Pharmacy Services

In addition to the above service models, pharmacy services have a significant role in the providing after hours services in the NT.

Pharmacists deliver vital after hours services, including providing medical advice, information on the management of minor ailments/conditions, filling urgent and non-urgent prescriptions and providing information about medications. Pharmacists are also able to refer people to a GP or other health provider for further assessment or advice.

Pharmacists are also extremely accessible in urban and regional areas. Of the 33 community pharmacies in the NT, 19 (57.5%) are open into the after hours period (that is beyond 6 pm). A pharmacy with extended hours is often co-located with an extended hours GP service. This may be due to consumer demand or in response to requests from the GP service.

People living in remote areas have much more limited access to pharmacists, both after hours and in the standard hours period, with medications generally supplied through the local remote health centre (whether managed by the Department of Health or an ACCHO), under the "s100" bulk supply scheme.

2.2 Primary care services operating during standard hours

As expected, the largest centre in the NT, Darwin, offers the highest proportion of services available in the after hours period. Many other services, including the majority of General Practices operate until 5 or 6 pm, with patients thereafter being referred (through either a formal or informal arrangement) to an existing after hours service and/or public hospital Emergency Departments.

In regional centres, a fairly high level of coordination and cooperation between services relating to after hours patient management was indicated. These centres have no comprehensive after hours service,[50] with referrals being made to the local hospital. Accordingly, most services only operate during standard hours.

In more remote areas, health centres (whether a Department of Health or ACCHO service) generally open between 8 am and 5 pm. Doctors may not always be in attendance, so staff at these centres are able to access either doctors associated with their service in the nearest centre, or the RMPs by telephone.

Remote clinics are responsible for delivering a significant number of health education programs, which are conducted during standard hours. One ACCHO noted that during standard hours, their visiting Doctor retains responsibility for delivering community health checks and chronic disease management, whilst the Nurses and Aboriginal Health Practitioners play the key role in management of any acute presentations. This occurs by reference to the CARPA Manual and liaison with the RMP.

[50] Noted that Katherine After Hours Service operates Tuesday and Thursday 7 - 9 pm, and Sunday from 10 am to 12 noon

Visiting specialist and allied health services are also available in remote and regional locations during standard hours.

Refer to Appendix A for a summary of the availability of health care services, including primary health care, hospitals and allied health services in the standard hours period.

2.3 Utilisation of services

As noted in 1.1.4, 78% of Territory adults surveyed had seen a General Practitioner in the previous year, with an average of 2.9 visits per adult per year. This compares to 3.5 visits per adult per year in other Medicare Locals within the same "Rural 2" classification.[51]

Emergency Department presentations to the NT's five public hospitals have increased over the last five years, from 125,119 in 2007-08 to 144,842 in 2011-12.[52] In 2011-12, Aboriginal people made up 56.3% of Emergency Department attendances.[53] T*he Hospitals - Australian Institute of Health and Welfare 2012: Australian hospital statistics 2011–12: emergency department care* report also notes that in the NT in 2011-12, the "selected potentially avoidable GP type presentations" to the Emergency Department made up 38% as a proportion of all presentations. Patients across the five triage categories[54] comprised of:

- Resuscitation – 712
- Emergency – 10,442
- Urgent – 40,475
- Semi-Urgent – 76,360
- Non-Urgent - 12,810[55]

The NT had the highest "semi-urgent", or Category 4, triage rate, at 54.2%, nearly 10% more than several other jurisdictions. It should be noted that semi-urgent and non-urgent presentations, otherwise known as Category 4 and Category 5 presentations may still be more appropriate to be seen in a hospital setting, and would not be appropriate to be seen by a GP even where those facilities were available.

TABLE 5: PUBLIC HOSPITAL TRIAGE CATEGORIES 2011-12[56]

Triage Category	NSW %	Vic %	Qld %	WA %	SA %	Tas %	ACT %	NT %	Total %
Resuscitation	0.6	0.5	0.8	0.8	1.2	0.5	0.4	0.5	**0.7**

[51] Namely Central and North West Queensland, Far North Queensland, Goldfields-Midwest (WA) and Kimberley-Pilbara (WA)
[52] Australian Institute of Health and Welfare, *Australian Hospital Statistics 2011-2012: Emergency Department Care*, Australian Government, 2012
[53] Ibid
[54] Refer to Appendix K, Australasian College for Emergency Medicine, Policy on the Australasian Triage Scale
[55] Ibid
[56] Australian Institute of Health and Welfare, *Australian Hospital Statistics 2011-2012: Emergency Department Care*, Australian Government, 2012

Triage Category	NSW %	Vic %	Qld %	WA %	SA %	Tas %	ACT %	NT %	Total %
Emergency	9.5	9.1	11.5	11.3	12.2	7.7	10.9	7.4	**10.1**
Urgent	31.5	32.7	42	32.3	36	33.8	33.4	28.7	**34.2**
Semi-Urgent	44.3	47.5	40.1	48.1	43.3	48	44.4	54.2	**44.9**
Non-Urgent	13.8	10.2	5.6	7.5	7.3	10	10.8	9.1	**10**
Totals	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Gove District Hospital data shows that there were around 8,700 presentations to the Emergency Department during 2011/12, of which 1,599 presentations (or 18.4%) occurred between 6 pm and midnight.[57]

Data from selected General Practices indicates that the busiest time for after hours service usage is between 7 and 9 pm on weekdays.[58] Practices that operate on a fee for service model may see between 5 and 10 patients a session[59], whereas bulk-billing services may see up to 20 patients per session. One large bulk-billing service in Darwin indicated that they can see up to 800 patients per week in the After Hours period when they have a full contingent of Doctors. Unfortunately data was not available to substantiate this statement on capacity prior to the finalisation of this report.

In remote settings, after hours service data provided by ACCHO across two distinct regions indicated high demand. Miwatj Health Aboriginal Corporation provided data for after hours services on Elcho Island, with a total of 3,689 patients being seen in the after hours period between January and December 2012, including 3,559 alone at the Ngalkanbuy Clinic.[60] This is from a core base population of approximately 2,200.[61]

Data provided by the Sunrise Health Service across seven clinics[62] indicates that 7,132 patients were seen in the after hours period. This ranged from between 89 patients at Eva Valley to 2,577 at Ngukkur (from a core population of 1,000 – 1,500[63]). The majority of patients were of Aboriginal origin, with females comprising 53% of patients and males 47%. Patients were seen for a variety of issues including pneumonia, coordination of evacuations, treatment following assaults, fractures, supply of medication (prescription and non-prescription).

The Health Direct Australia telephone help-line has operated in the NT since July 2011, incorporating the previous NT Government run telephone helpline. Data available from Health Direct Australia After Hours GP Helpline indicates that in the second quarter in 2012, the service received 421 calls from the NT (out of a population of 233,300). This is in comparison to a service such as the Ngukurr

[57] Data, Gove District Hospital 2012
[58] Data Alice Springs After Hours General Practice, January – December 2012
[59] Data Alice Springs After Hours General Practice, January – December 2012
Email Ruth Debuque, Casuarina Square Medical and Dental to Victoria Hirst, 5 March 2013
[60] Data Miwatj Aboriginal Health Corporation, January – December 2012
[61] Extracted from: http://en.wikipedia.org/wiki/Elcho_Island
[62] Namely Barunga, Bulman, Eva Valley, Mataranka, Minyerri, Ngukkur and Wugularr
[63] Extracted from: http://www.sunrise.org.au/sunrise/bottomroad.htm

Health Centre who, on figures provided, would attend 644 after hours calls in a similar time period (out of a population of 1,000-1,500).

Females made up the majority of these callers (57.4% female to 42.6% male)[64], with 6 to 11 pm being the busiest time, with over 56.2% of calls receiving during these hours.[65]

The majority of callers had originally intended to contact a Doctor or attend at the Emergency Department prior to calling.

TABLE 6: TOP FIVE ORIGINAL INTENTIONS OF CALLERS TO HEALTH DIRECT AUSTRALIA AFTER HOURS GP TELEPHONE HELPLINE– SECOND QUARTER 2012 - NT[66]

Original Intention	Volumes	Volumes %
Contact Doctor//Healthcare Provider	118.0	28.0
Attend Emergency Department	106.8	25.4
Did not know what to do	98.5	23.4
Home/Self Care	70.2	16.7
Non-Professional Advice	10.0	2.4
Other Intentions	17.4	4.1
Total	**421.0**	**100.00%**

The most frequently diagnosed issue was “Rash/Hives/Eruptions”, followed by “Nausea/Vomiting” and other minor health matters, categorised according to the services guidelines.[67]

TABLE 7: TOP FIVE DIAGNOSTIC GUIDELINES OF ISSUES BY CALLERS TO HEALTH DIRECT AUSTRALIA AFTER HOURS GP TELEPHONE HELPLINE– SECOND QUARTER 2012 - NT[68]

Guidelines	Volumes	Volumes %
Rash/Hives/Eruptions	15.8	3.8%
Nausea/Vomiting	11.4	2.7%
Diarrhoea/Change in Bowel Habits	10.4	2.5%
Chest Pain/Discomfort	10.0	2.4%
Headache	9.0	2.1%

[64] Data from Health Direct Australia, Northern Territory, Second Quarter 2012
[65] Ibid
[66] Ibid
[67] Refer Appendix L, Classification Guidelines Used by Triage Nurses for Patients in the Northern Territory
[68] Ibid

Other Guidelines	346.3	82.27%
Total	**421.0**	**100.00%**

The majority of callers (51.3%) were recommended to undertake some form of self-care, before seeing a GP. Just under a third of callers (32%) were referred to a medical service immediately. Whilst the figures in the below table represent the advice given to callers; it is not possible to ascertain which patients followed this advice and/or which patients immediately attended on a service.

TABLE 8: TOP FIVE OUTCOMES OF CALLS TO HEALTH DIRECT AUSTRALIA AFTER HOURS GP TELEPHONE HELPLINE– SECOND QUARTER 2012 - NT[69]

GP Call Outcome	Volume	Volume %
Self-Care Advice and See GP in Hours	215.9	51.3
GP Immediately	52.6	12.5
ED Immediately	52.2	12.4
Self-Care Advice Only	44.6	10.6
GP Immediately [No GP Available - Go to ED]	30.0	7.1
Other Outcomes	25.6	6.1
Total	**421.0**	**100.0%**

On the data provided, the majority of callers *were not* advised to go to their local Emergency Department, yet many providers (particularly in private practice) believed that the majority of callers *were* advised to attend at Emergency Department, either due to lack of clinical training by operators or through the service's fear of potential litigation.

Many services also indicated that patients had advised them that they were attending appointments on the basis of advice received by the Health Direct Australia service.

Data is not available on the Indigenous status of the caller, although providers consulted believed that the service is mostly utilised by non-Indigenous Territorians. Some concerns were expressed relating to lack of knowledge about available local services by Health Direct Australia operators. Health Direct Australia currently utilises the National Health Services Directory (http://nhsd.com.au/) which provides information on opening hours etc. but no contextual information on services or other factor such as available ancillary services (e.g. pharmacies).

[69] Ibid

2.3.1 NT Wide

As indicated above, utilisation of after hours services, through hospitals, GP, remote clinics and calls to the after hours telephone help-line is high. Factors which impact on utilisation of services in urban, regional and remote areas include the availability of services, the accessibility of those services (either through cost or physical accessibility after hours), and patients' knowledge of those services.

These issues vary across the NT (and include issues discussed at 1.2 above). Common factors influencing service utilisation in remote centres (e.g. Darwin Rural, East Arnhem, Alice Springs Rural) include:

- Factors associated with distance, e.g. limited services being available on the ground, with visiting services, and patients needing to travel;
- Weather conditions which may limit available visiting health services;
- Infrastructure, including the quality of the air strips in remote communities, which may limit health services;
- Staff turnover is generally high and recruitment can take a long time;
- Staff accommodation is at a premium or non-existent in some areas; and
- Staff attending after hours on-call services having a flow-on effect on standard hours services and health program delivery.

Due to constraints on time associated with the project, consumers were unable to be directly engaged. The NTML has a commitment to engaging with consumers of after hours health services, and this will be an ongoing process throughout 2013/14, through the Consumer Advisory Group, which will report directly to the NTML Chief Executive Officer.

The NTML will also be undertaking further engagement with providers of primary health care and other allied health services through governance groups such as the Therapeutic Advisory Group, Community Health Committee, Aboriginal Health Committee and Clinical Governance Advisory Group, together with more informal processes and networks.

2.3.2 Darwin Urban

- Availability

The Darwin urban area is largely well-serviced with a large range of private GP services, a public and private hospital, several Community Health Clinics, two ACCHO, a GP Super Clinic, overnight Urgent Care Service, and other medical services such as sexual health clinics. Many allied health services and visiting specialist are available, although waiting lists may be long. A range of pharmacists are open for extended hours (generally until 9 pm on weeknights and over the weekend) who can fill prescriptions, and provide advice and assistance with minor medical ailments and conditions.

Seven GPs across Darwin (including in the city, Northern suburbs, Palmerston and Greater Darwin) are open until 9 or 10 pm, with patients after this time generally referred to the Royal Darwin Hospital. This equates to just over 20% of General Practices servicing the Darwin Urban area.

Many General Practitioners interviewed offer limited on-call services, including home visits for palliative care patients and to aged care facilities. This service may be offered even where the General Practice does not provide a discrete after hours service. Several General Practices (generally those receiving Tier 3 of the After Hours Practice Incentive Payment) provide an on-call number for their patients. Telephone triaging is then conducted, with the Doctor on-call having access to the patient's records via remote computer access, before referral to either the Hospital or the next standard hours service. No service indicated that they would generally arrange a clinic meet-up after hours. This service was generally only available for existing patients of the practice.

Other after hours services will accommodate patients from other practices, with many after hours services (e.g. at the Palmerston Medical Centre, Casuarina Square Medical and Dental, Northlakes Medical Centre) provided on a 'walk-in' basis. Patients at the PUCAHS are also seen on a triaged 'walk-in' basis.

- Accessibility

After hours bulk-billing services are available in Darwin and in the Palmerston area. Services provided at the Royal Darwin Hospital and the PUCAHS are free.

Public transport is available in Darwin and Palmerston (on some routes until 10 or 11 pm), but is much more limited in the Greater Darwin area.

The security of accessing after hours services was highlighted by several providers, with one GP that they had received feedback from more elderly patients that they had felt safer accessing the service at night due to its location, namely located in a suburban shopping centre with a busy supermarket open until 10 pm. The security of staff (both in the clinic and walking to their cars after work) was also seen as a key issue in the provision of after hours services. As noted above, on-call after hours services and home visits for palliative care or to aged care facilities is generally only provided to existing patients of the practice, who are known to the treating Doctor.

- Knowledge and awareness of services

Services in the Darwin urban region had a very good knowledge of each other, including opening times, waiting times etc. Several practices have multiple branches, and patients are able to be referred between them where appropriate.

Project staff were advised that the service directory of General Practice services previously developed by the General Practice Network of the NT, and now updated by the NTML, is utilised by Doctors at the Royal Darwin Hospital Emergency Department when speaking to patients about GP services. The directory is used for patients who may not have a usual GP, so that they are able to select a GP in their area, with knowledge of their fees (if any) and opening hours. However, due to the current format of this directory (large Excel spread sheet) it has limited uses for this purpose.

- Other factors which may impact on the utilization of services

Several private practitioners noted that the GP Super Clinic at Palmerston had an initial impact on their patient numbers, however this seems to have been absorbed by new patients, and/or due to the lessened impact since the Super Clinic extended their hours (and the fee for service time period) until 10 pm in late 2012.

Many private practitioners expressed concern about the proposed Super Clinic to be located in Malak, in the Northern Suburbs in Darwin, and felt that this could have a significant impact on their business, especially if this was a bulk-billing service. As of February 2013, advice from the Department of Health and Ageing indicates that "The competitive funding process closed in June 2011 with no applications received, and the process has now moved to a direct funding process. 'Without prejudice' negotiations are underway with a view of offering a new funding agreement subject to the successful outcome of the negotiations."[70]

At the time of finalising this report, the current NT Government's position on the development and operation of the Super Clinic was not able to be ascertained, with the matter raised in the most recent Legislative Assembly sittings in late February 2013.

Concerns were also raised about the quantum of government funding (both Territory and Federal) given to the Super Clinic services and the PUCAHS, with frustration aired that implementing these services can have severe consequences for private businesses already operating.

Staff from Ochre Health (providers of clinical staff to the PUCAHS) advised that their currently service delivery contract is due to expire by 30 April 2013, and it is unknown (at the time of preparing this needs assessment report) whether this contract will be renewed in the short-term, or the service is put out to tender. This service currently operates from the Palmerston Super Clinic overnight (10 pm-8 am), with separate providers (FCD Health) providing services from 8 am – 10 pm.

Many private practices also noted the impact of the *Health Professionals and Support Services Award 2010* which had impacted their ability to negotiate with administrative staff to work outside standard hours. Administrative staff wages was identified as a key barrier for some practices in providing an after hours service.

St John Ambulance will shortly commence piloting the ECP Program in the Greater Darwin region (within 90 kilometre radius of Darwin). This program enables specially trained paramedics to provide a wider variety of medical services (e.g. suturing, providing some medications) to patients, with the aim of them being diverted from the Royal Darwin Hospital. At this stage it is not clear what impact this may have on the utilisation of other after hour's services, but good networks have been established between NTML project staff and St John Ambulance, and this service will continue to be monitored.

[70] Extracted from: http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics-latestnews-darwin

As described below, there are several major projects underway in the Greater Darwin area, resulting in an increased workforce in the next 10 – 20 years. This will have a resultant impact on all services, including health services.

2.3.3 Darwin Rural

- Availability

Services in the Top End region are provided largely by the Department of Health, with some ACCHO also operating.

The availability of GP and other health services (including allied health services, specialists and pharmacists) varies across the region and between communities. Services in some areas are largely led by Nurses and Aboriginal Health Practitioners, with telephone and visiting support from the RMPs.

- Accessibility

Health Centres are available on-call after hours, with support provided by RMPs on call through the Royal Darwin Hospital. Evacuations are undertaken by Careflight. As described elsewhere, there are access issues for people in remote communities due to the distance, road conditions and seasonal factors.

After hours services are available to existing patients of the health centre and to other patients requiring assistance, such as Pastoralists or tourists.

The security of staff attending after hours calls was raised as an issue in both Stages of this Project. Remote Health Centres have limited resources to engage local staff to assist in the after hours period to improve staff and patient safety. Many Remote Health Centres have very small teams which result in staff having to work alone at night, including attending at patient's homes, when called out. This entails attending the clinic, contacting the RMP on call and possibly assisting with a medivac (possibly including assisting in lighting and clearing the air-strip) late at night. Reliance on community volunteers to assist in this process can be problematic, which may therefore increase any safety risks to the actual staff member and or the patient. Remote Health Centre staff generally work very closely with the Police and Night Patrol services to assist in their after hours work.

2.3.4 East Arnhem

- Availability

In the Nhulunbuy township and nearby Yirrkala and Gunyangara Communities, services are available through the Gove District Hospital, Miwatj Health Clinics (in Nhulunbuy and at Yirrkala and Gunyangara), a private GP service and NT Government Community Health Centre.

Outside of Nhulunbuy, outreach services are offered in the Laynhapuy Homelands and on Elcho Island. These services operate during standard hours; however staff are contacted by patients after hours, and will provide assistance in liaising with the RMP or other available health service.

Remote Health Centres (incorporating visiting Doctors, specialists and allied health workers) are available throughout the rest of the region, with varying availability of GPs. For example, GP's are located in Galiwin'ku and on Groote Eylandt, but not elsewhere. Services in other areas are generally Nurse led, with telephone and visiting support from the RMPs.

- Accessibility

Within Nhulunbuy, the privately owned GP service, the Endeavour Medical Centre, provides limited on-call services, including home visits for palliative care patients and to aged care facilities, and telephone triage and advice to longer-term patients of the practice.

Patients requiring after hours services if they are located in or near the Nhulunbuy township, generally attend at the Gove District Hospital. Outside of Nhulunbuy, patients contact their local Remote Health Centre, where staff will liaise with the RMP on-call who will arrange an evacuation if necessary. After hours services are available to existing patients of Remote Health Centres, and to other patients requiring assistance, such as Pastoralists or tourists.

The Endeavour Medical Centre is a fee-for-service practice, with other services free or bulk billing. There is no public transport in Nhulunbuy; however there is a taxi service, and a "bush taxi" which attends nearby outstations. Fares for this service can run into several hundred dollars.

Evacuation services are provided by Careflight. St John Ambulance has a station in Nhulunbuy with one crew working. This can create difficulties where Ambulance services are requested outside Nhulunbuy (e.g. in homeland and outstation communities), with no St John ambulance crew then available to service the Nhulunbuy township.

As described elsewhere, there are access issues for people in remote communities due to the distance, road conditions and seasonal factors.

The security of staff attending after hours calls was raised as an issue in both Stages of this Project. Remote Health Centres have limited resources to engage local staff to assist in the after hours period to improve staff and patient safety. Many Remote Health Centres have very small teams which result in staff having to work alone at night, including attending at patient's homes, when called out. This entails attending the clinic, contacting the RMP on call and possibly assisting with a medivac (possibly including assisting in lighting and clearing the air-strip) late at night. Reliance on community volunteers to assist in this process can be problematic, which may therefore increase any safety risks to the actual staff member and or the patient. Remote Health Centre staff generally work very closely with the Police and Night Patrol services to assist in their after hours work.

- Knowledge and awareness of services

The Gove District Hospital is well known across the region as the point of call for after hours care or when usual point of care services are not available.

2.3.5 Katherine

- Availability

In the Katherine urban region, services are available through the Katherine Hospital, two private GP services, and NT Government Community Health Centre, or the ACCHO. A dentist, chiropractic, pharmacy and some diagnostic services are available locally in Katherine, with other visiting specialist services available. Patients are able to access these services through the public system or as private patients. Two pharmacies are open in the Katherine township.

Currently, outside of the Katherine Hospital, only a limited after hours service is available through the Katherine After Hours Service operated through Gorge Health (one of the private GP services.) This has been operating for approximately 18 months, and provides bulk-billed after hours services on Tuesday and Thursday night and Sunday mornings. This service was developed through a General Practice After Hours grant funding. It is reported to be well-utilised, with an average of 15 patients per session. The other General Practice service provides after hours on-call work, including one of the Principals being on-call through the Katherine Hospital for obstetrics and anaesthetics.

The broader Katherine region is serviced by two ACCHO; Sunrise Health Service to the East and Katherine West Health Board to the West. A clinic at Binjari is operated by Wurli Wurlinjang. Following regionalisation and services coming under community control, the Department of Health has a limited presence in remote clinics in this region; however the RMPs are used to assist workers, particularly with after hours services.

- Accessibility

In the Katherine urban region, the two private GPs are fee-for-service practices (Katherine After Hours is a bulk-billing service). Services at the Katherine Hospital, Wurli Wurlinjang and Community Health Centre are free.

There is no public transport in Katherine; however there is a taxi service. St John Ambulance has a station, with one crew working at a time. If St John Ambulance are required to attend “rendezvous” to meet people from remote centres, a crew will be available on stand-by to cover the town.

Residents in the broader Katherine region face similar issues relating to access to service as in other areas in the NT, namely that services are available on-call after hours, with the services provided through a Nurse/Aboriginal Health Practitioner in the first instance, who will then liaise with the relevant RMP. Evacuation services are provided by Careflight. As described elsewhere, there are access issues for people in remote communities due to the distance, road conditions and seasonal factors.

The Katherine After Hours Service accommodates patients from other practices, with patient’s notes being sent back to their usual treating Doctor. In the broader Katherine region, after hours services are available to existing patients of Remote Health Centres, and to other patients requiring assistance, such as Pastoralists or tourists.

- Knowledge and awareness of services

Consultations with providers indicated a high level of awareness of services, in both the town and remote centres. The two ACCHO operating in the broader Katherine region face many similar issues in after hours call-out work and impacts on standard hours services, recruitment and retention, and staff accommodation.

Within Katherine, services had a good knowledge of each other, and members of the Katherine Town Council and other service providers indicated a high level of awareness of the After Hours service. The Katherine After Hours Service conducted a consumer survey in 2012 indicating that 40% of respondents had heard about the survey from "word of mouth", with 28% hearing about the service from another source, such as advertisements at the caravan park or through the local pharmacy.[71]

- Other factors which may impact on the utilization of services

Discussions are presently underway relating to the expansion of mining operations near Katherine. If this project continues, the Katherine Town Council projects that Katherine's population could double in the next five to 10 years,[72] with the population including families, not generally single male workers. This would have resultant impacts on all services in Katherine, including health services.

2.3.6 Barkly

- Availability

In Tennant Creek, services are provided through a GP service auspiced by the RFDS and Anyinginyi, an NT Government Community Clinic, and the Tennant Creek Hospital. There are limited visiting specialist and allied health services in Tennant Creek. One pharmacy is open in Tennant Creek, which does not open in the after hours period. Maternity services are not available in Tennant Creek, with most women travelling to Alice Springs two weeks prior to their due date.

Currently, no separate after hours services are provided outside of the Tennant Creek Hospital. Doctors from Anyinginyi do provide on-call services to the local aged care facility four nights per week.

In the broader Barkly region, services in remote areas are provided by Anyinginyi Regional and Remote section, which services most of North Barkly except Elliott. This includes cattle stations, and the Department of Health. The RMP model operates in the Barkly, with evacuation services provided by the RFDS.

- Accessibility

In Tennant Creek, the GP service offered by the RFDS is a fee-for-service practice. Services at the Tennant Creek Hospital, Anyinginyi and the Community Health Centre are free.

[71] Survey, Katherine After Hours Service, 2012
[72] Consultation, Katherine Town Council, 26 February 2013

There is no public transport in Tennant Creek; however there is a taxi service. St John Ambulance has a station.

Residents in the broader Barkly region face similar issues relating to access to service as in other areas in the NT, namely that services are available on-call after hours, with the services provided through a Nurse/Aboriginal Health Practitioner in the first instance, who will then liaise with the relevant RMP. As described elsewhere, there are access issues for people in remote communities to medical services (including allied health services, specialists and pharmacists) due to the distance, road conditions and seasonal factors. In the broader Barkly Region, after hours services are available to existing patients of Remote Health Centres, and to other patients requiring assistance, such as Pastoralists or tourists.

The security of staff attending after hours calls was raised as an issue in both Stages of this Project. Remote Health Centres have limited resources to engage local staff to assist in the after hours period to improve staff and patient safety. Many Remote Health Centres have very small teams which result in staff having to work alone at night, including attending at patient's homes, when called out. This entails attending the clinic, contacting the RMP on call and possibly assisting with a medivac (possibly including assisting in lighting and clearing the air-strip) late at night. Reliance on community volunteers to assist in this process can be problematic, which may therefore increase any safety risks to the actual staff member and or the patient. Remote Health Centre staff generally work very closely with the Police and Night Patrol services to assist in their after hours work.

- Knowledge and awareness of services

Within Tennant Creek, services consulted had a good knowledge of each other and positive working relationships. The need to coordinate services was seen as paramount, and the three key agencies (Tennant Creek Hospital, Anyinginyi and RFDS) meet regularly to discuss relevant local issues.

2.3.7 Alice Springs Rural

- Availability

Health Centres and GP services are available on-call after hours, with support provided by RMPs on call through the Alice Springs Hospital. Evacuations are undertaken by the RFDS.

Services in this region are provided largely by the Department of Health, with some ACCHO also operating. The availability of GP and other health services (including allied health services, specialists and pharmacists) varies across the region and between communities. Services in other areas are largely Nurse led, with telephone and visiting support from the RMPs.

- Accessibility

As described elsewhere, there are access issues for people in remote communities due to the distance, road conditions and seasonal factors. After hours services are available to existing patients of Remote Health Centres, and to other patients requiring assistance, such as Pastoralists or tourists.

The security of staff attending after hours calls was raised as an issue in both Stages of this Project. Remote Health Centres have limited resources to engage local staff to assist in the after hours period to improve staff and patient safety. Many Remote Health Centres have very small teams which result in staff having to work alone at night, including attending at patient's homes, when called out. This entails attending the clinic, contacting the RMP on call and possibly assisting with a medivac (possibly including assisting in lighting and clearing the air-strip) late at night. Reliance on community volunteers to assist in this process can be problematic, which may therefore increase any safety risks to the actual staff member and or the patient. Remote Health Centre staff generally work very closely with the Police and Night Patrol services to assist in their after hours work.

2.3.8 Alice Springs Urban

- Availability

Within Alice Springs there are five private GP services operating, with one ACCHO, an NT Government Community Clinic and the Alice Springs Hospital. The ACCHO (Congress) provides a women's clinic. Other allied health services and visiting specialist services are available. Four pharmacies are open in Alice Springs, including several over the weekend. None are open beyond 7 pm on weeknights.

One private GP provides after hours on-call services, which may include after hours clinic meet-ups.

The Alice Springs After Hours GP Service (known locally as the "ASAP Clinic") provides dedicated after hours services until 9 pm on weekdays and for several hours on Saturdays and Sundays. This is a fee-for-service clinic, with local GPs working on the roster.

Congress provides a comprehensive after hours services until 8 pm weekdays and on Saturdays and Sundays. The Alice Springs Hospital remains the primary referral point for other after hours requirements.

As in other locations, after hours on-call services are generally provided to long-term patients, palliative care patients or patients in aged care facilities.

- Accessibility

Congress provides a free after hours service, with all after hours services in Alice Springs being fee-for-service practices.

As noted above, General Practitioners interviewed in Alice Springs offer limited on-call services, including home visits for palliative care patients and to aged care facilities. This service may be offered even where the General Practice does not provide a discrete after hours service. Several General Practices (generally those receiving Tier 3 of the After Hours Practice Incentive Payment) provide an on-call number for their patients. Telephone triaging is then conducted, with the Doctor on-call having access to the patient's records via remote computer access. The patient may then be referred to the Alice Springs Hospital, to a standard hours service, or a clinic meet-up may be

arranged. This service (and particularly the clinic meet-up service) was only available to existing patients of the practice.

The security of accessing after hours services was highlighted by several providers, with this being a key issue in the provision of after hours services. As noted above, on-call after hours services are generally only provided to existing patients of the practice, who are known to the treating Doctor.

- Other factors which may impact on the utilization of services

The Alice Springs After Hours GP Clinic is funded through a General Practice After Hours Grant. This funding will expire on 30 June 2013, with this funding pool being absorbed into the After Hours Stage 2 funding. However, there are indications the service may end prior to 30 June 2013 to ensure that there are adequate funds to cover any winding up expenses. Whilst the current Directors may not wish to continue operating this service, it is believed that there is support for this service to continue under changed governance structures.

The Alice Springs Hospital is currently undergoing renovations, which may prevent access to the Clinic in its current space. Initial indications were that a space could be made available within the hospital campus for this Clinic to continue, but further discussions would be required with the Department of Health and the Alice Springs Hospital.

2.4 Workforce capacity

Workforce shortages are widely recognised as a significant barrier to the provision of health care in the NT. A major reason behind high staff turnover, particularly in remote areas, is burnout caused by overwork and insufficient resources to deal with the health issues faced. Others may leave due to a variety of social factors; people may feel isolated from friends and families and it is difficult to find fulfilling work for working couples in a small community[73].

The exact health workforce capacity of the NT is difficult to quantify, with variations due to funding, vacancies and the level of skills and experience of the Doctors, nurses, Aboriginal Health Practitioners, and allied health workers employed. For example, at the Gove District Hospital, the Doctors are GP's, but more than half are Registrars. Of the qualified GP's, over half are International Medical Graduates, and some of the medical staff share their time with other medical services in the region.[74]

Many areas in the NT, including urban centres, experience a high number of visiting specialists including Paediatrics, Surgery, Renal, Cardiology, Ophthalmology, Gastroenterology, Rehabilitation, ENT, Gynaecology, and Neurology who may schedule visits to both urban and regional/remote areas on a monthly or quarterly (or longer) basis.

[73] Flinders University Northern Territory Rural Clinical School, *Proposal for Nhulunbuy Medical Teaching Clinic*, 2009
[74] Ibid

Various workforce studies have been undertaken, including specific research on recruitment and building the capacity of the Indigenous workforce and developing appropriate models for Indigenous primary health care.[75]

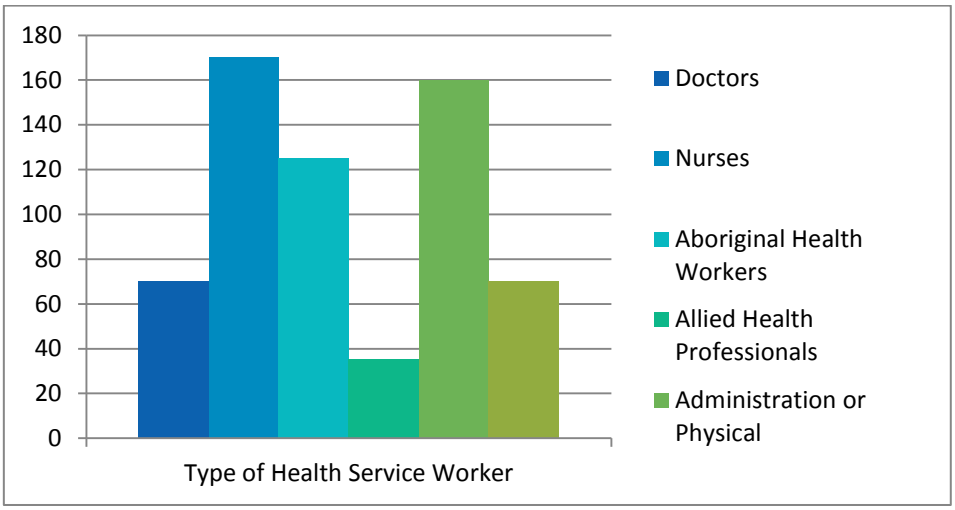
Recommendations arising from a multi-disciplinary workshop organised by the former General Practice Network of the NT, included:[76]

- that there be one Full Time Workload Equivalent GP working in Aboriginal primary health care for every 800 Aboriginal patients; and
- that GPs working in Aboriginal primary health care needed a balanced workload of 70% clinical work with 30% non-clinical work (e.g. teaching, administration, public health matters).

Workshop participants also noted that the role of the GP in the remote NT context, and particularly in ACCHO, is very broad and there is a need to consider the full primary health care team in clinical service delivery. This may cause profound culture shock for some new GPs.[77]

As part of the *Aboriginal Health Worker Workforce Review* undertaken in 2009, a survey of Aboriginal primary health care services was completed, with 41 survey respondents. This survey showed the diversity of staffing in Aboriginal primary health care services, with Nurses and Aboriginal Health Practitioners clearly outnumbering Doctors in these services.

FIGURE 6: AVERAGE STAFFING COMPOSITION OF ABORIGINAL PRIMARY HEALTH CARE SERVICES – 2009[78]



[75] Bartlett, Ben and Duncan, Pip, *Top End Aboriginal Health Planning Study: Report to the Top End Regional Indigenous Health Planning Committee of the Northern Territory Aboriginal Health Forum*, 2000
Bartlett, Ben, Duncan, Pip, Alexander, David and Hardwick, Jill, *Central Australian Health Planning Study*, 1997
[76] General Practice Network of the Northern Territory Workshop Report, *Sustainable General Practice in Aboriginal Primary Health Care in the NT*, 2004
[77] Ibid
78 Human Capital Alliance, Framework for the Development of the Primary Health Care Workforce in Aboriginal Health in the Northern Territory, 2011

Providers consulted in regional and urban settings advocated the need for increased levels of Aboriginal Health Practitioners and other Aboriginal staff. Such workers may act as liaison between members of the community and other health practitioners, and assist in providing important health information in culturally appropriate ways. The benefits of recruiting and retaining appropriately qualified and supported local people cannot be overstated.

Since being opened up to Medicare billing, the monetary impact of services offered by Aboriginal Health Practitioners has been able to be assessed. Data shows high level of service by Practice Nurse and Aboriginal Health Practitioners, with over 22,000 billable services performed from January to December 2012, at a value of $396,279.[79] This included 2,843 immunisations (at a value of $33,556) conducted by Aboriginal Health Practitioners and 2,815 wound dressings (at a value of $33,283) conducted by Aboriginal Health Practitioners.[80]

During the consultations, the value of the Nurse Practitioner[81] role was repeatedly emphasised as one option to assist with service delivery and possibly alleviate some workforce issues relating to recruitment and retention. There are not currently many (estimated at no more than 10)[82] Nurse Practitioners working in the NT, with several in training at the Gove District Hospital.

In 2011-12 there were 479 GPs working in the NT, up from 413 in 2009-10.[83] The GP workforce in the Territory is generally evenly split between males and females, with 33.4% of GPs qualifying outside Australia in 2011-12. This is up slightly from 31.9% in 2009-10.[84]

A key challenge in health service delivery in the NT is the development and maintenance of a technically and culturally competent workforce to support the sustainable delivery of services and programs.

Many local regions, together with peak bodies such as AMSANT, have already done significant work in this space. This includes the *East Arnhem Region Health Service Delivery Area Health Service Reform Plan*[85] which outlines strategies for addressing workforce development. The Plan acknowledges that the delivery of integrated comprehensive primary health care services requires providers to think about the health system more broadly than the clinic or community in which they work. This requires not only working in multi-disciplinary teams in the clinical setting, but also establishing linkages with community groups and services to better promote and implement population health initiatives.

[79] Medicare Australia, Divisions of General Practice Statistics, Northern Territory Division of General Practice, MBS Statistics – Non Referred Attendances
[80] Ibid
[81] Nurse Practitioners are specialist nurses working in an extended "scope of practice that may include diagnosing, prescribing, ordering investigations, admission and discharge, and referrals." Northern Territory Department of Health, *What is a Nurse Practitioner*,
[82] Consultation, NTML Workforce Unit, 13 March 2013
[83] NTML Profile report, 2013
[84] Ibid
[85] East Arnhem Clinical and Public Health Advisory Group, *East Arnhem Region Health Service Delivery Area Health Service Reform Plan*, 2012

Strategies in the Plan included:

- Increasing Aboriginal and Torres Strait Island people's participation in the health and community services workforce through:
    - Establishing supportive training pathways to promote retention in training and completion of qualifications
    - Innovative and culturally relevant workplace recruitment, employment and retention strategies
    - Equitable employment conditions.

- Equipping non-Aboriginal and Torres Strait Island health professionals to deliver culturally secure and evidence based comprehensive primary health care through orientation and induction processes relevant to East Arnhem promoting culturally secure and technically relevant care.

These principles would be applicable across the region, and not solely in East Arnhem.

ACCHO have developed mechanisms to consult with their local community, who are represented through their governance structures. Katherine West Health Board holds annual "performance review" community meetings, where services can be reviewed and discussed. Other ACCHO have started to develop evaluation protocols for after hours services, and consumer groups to assist in the development of culturally appropriate health education materials.

Many practitioners, both in private practice and across ACCHO indicated that workforce issues had a significant effect on the delivery of after hours services due to "work – life" balance issues and burn-out. Many Doctors currently providing after hours services at a dedicated after hours service (e.g. at the Alice Springs After Hours Clinic or Rapid Creek After Hours Clinic) do so in addition to their usual day's work. Several ACCHO noted that the lack of responsibility to undertake after hours services was seen as a "selling point" in recruitment of clinical staff to their service.

There are numerous incentives available to attract and retain clinical staff to the NT. These include, pre-employment site visits, relocation grants, orientation and training grants and workforce support. This includes GP Rural Incentives Program Grants, with incentives paid to Doctors providing services in rural and remote areas based on the amount of time worked in the area, the remoteness and the level of service, and the Continuing Professional Development Rural Grant. Staff may have access to other incentives and training related to their employment through different employers (i.e. the NT Government).

2.5 Any other issues relevant to current access and availability of services

In addition to the specific regional factors noted at 2.4 above, consultations identified a variety of other issues that relate to current access to, and availability of, after hours primary health care services. These included:

- System and performance issues
  - Coordination of care between primary health care services and hospitals, and amongst other primary health care services;
  - The use of emerging technologies such as telemedicine and diagnostic equipment able to be used in remote settings;
  - e-Health and the ability for patient records to be accessed across multiple agencies to improve coordination;
- RMPs being unable to access Medicare – raised as a particular issue in terms of RMPs accessing telemedicine services;
- Short term funding is disruptive to support service programs (and hence patient referrals to these non-clinical services);
- Crisis, respite and short term accommodation for patients is limited or non-existent in areas;
- Piloting of the St John Ambulance ECP Program. This service will commence trials in the Greater Darwin region from mid-March to 30 June 2014. This service model may be appropriate for other regional centres, including Katherine and Nhulunbuy, where after hours services are very limited;
- The ongoing impact of the Australian Governments *Stronger Futures* package in the NT. *Stronger Futures* states the Australian Government's support for the "continued expansion and reform of primary health care with a focus on regional, community-controlled health services" will continue,[86] with the following services[87]:
  - More alcohol and other drug treatment services;
  - Better support for mental health and care for people with severe and debilitating mental illness;
  - Improved specialist and allied health care services for children; and
  - Improved therapeutic services for children who have been victims of child abuse.
- Impending changes to the NT Department of Health structure;
- Impact of government measures on service delivery by private business – administration award, funding to service providers (super clinic and Palmerston Urgent Care After Hours Service); and
- Review of the Opiate Pharmacotherapy Program and Needle and Syringe Program by the Department of Health. These reviews may include consideration of pharmacy opening hours and availability of these services across all regions of the NT

In addition to the matters noted above, there are other developments in the NT which may affect the future of after hours primary health care service delivery in the NT, primarily due to their effect, either positively or negatively, on population growth (and therefore demand for services). These include:

[86] Phillips Jacqueline, Franklin Emma, and Viswanathan Rajiv, *A Better Way: Building healthy, safe and sustainable communities in the Northern Territory through a community development approach* 2011
[87] Ibid

- Exploration and resource services in Darwin and Katherine, namely the Inpex and Wickham Gas Plant in Darwin and the proposed expansion of the Mt Todd mine in Katherine;
- The potential closure of the refinery at Nhulunbuy (at the time of completing this report this issue appears to be resolved); and
- Discussions relating to a potential uranium mine development near Alice Springs (at the time of completing this report there have been no further developments on this mine).

Chapter 3 – Issues and Gaps

Developing an understanding of the issues/gaps in access to after hours primary care services in the Northern Territory

As noted above, there are a variety of after hours primary health care services available across the NT, with access varying according to services that are available, cost etc.

Considering the findings of the needs assessment, the following issues and gaps in access to after hours primary health services were detailed:

- The availability of future funding for after hours primary health care services post 1 July 2013;
- Likely ending of the current dedicated after hours service in Alice Springs and the need to develop a service which is accessible, affordable and best meets the needs of the local community;
- Limited availability of After Hours Services in Katherine;
- Limited availability of After Hours Services in Tennant Creek;
- Lack of awareness of after hours services and their use – different requirements in urban and regional/remote settings;
- Security for remote health centre staff attending after hours call-outs;
- Limited after hours medical services in the Laynhapuy Homelands;
- The impact of workforce issues, including recruitment, retention and staff burn-out has on the delivery of after hours services;
- The impact that issues of remoteness (including transport, infrastructure and limited available services) has on the delivery of after hours services;
- The availability and use of new technologies, such as telemedicine, in the after hours period;
- Possible change in provider to deliver the Palmerston Urgent Care After Hours Service;
- Potential impact of the proposed Northern Suburbs GP Super Clinic (proposed for Malak in the Northern Suburbs in Darwin) on local services;
- Access to pharmacy services after hours;
- Lack of consistent data collection on the use of after hours services (focus on East Arnhem);
- Disparity between perceived consumer response to advice from Health Direct Australia when compared with available data;
- Infrastructure
    - Katherine Hospital
    - St John Ambulance (Katherine)
    - Endeavour Clinic (Nhulunbuy)
- Government policies
    - MBS Amount not reflective of services provided, particularly in the After Hours period;

- Impacts of the *Health Professionals and Support Services Award 2010* on wages;
- Government subsidies and impact on private business

- Future research may be required on the following issues:
  - Lack of clear consensus from practitioners and/or consumers on what After Hours services should provide and who should provide them;
  - Use of Public Hospital Emergency Departments for Primary Health Care matters, based on historical use and lack of other services; and
  - After hours health care settings that are culturally appropriate for Indigenous consumers.

It is acknowledged that several of these issues and gaps relate to much broader issues, with some concerning physical issues such as distances and the weather. The NTML does not expect that those issues can be addressed within the funding available under the After Horus Program, but they are raised here as they relate to the context of access to after hours primary health care services.

These systemic issues will be referred to the Health Needs Assessment Project Team and Steering Committee for their consideration.

Outline and description of all gaps and issues identified in after hours primary care - not in ranked order

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
The availability of future funding for after hours primary health care services post 1 July 2013	<u>After Hours Practice Incentive Program (PIP) Payments</u> Currently, 25 General Practices and Aboriginal Community Controlled Health Organisations receive some form of After Hours PIP Payment across the NT. This payment is made direct by Medicare to services. Limited data is collected by Medicare on this payment. Concerns were expressed by providers across the NT, those receiving the after hours PIP payment and those not, that there are systemic issues with the current system, with the focus being on what services are offered, rather than what services are in fact utilised. The example was given of after hours on-call services being offered, but with a high call-out fee being charged to see a Doctor, making the service prohibitive for some patients, who would then choose to attend an alternate service or visit that Doctor during standard hours. Tier 1 of the current payment structure requires practices to make sure that regular practice patients have access to after hours care, 24 hours a day, seven days a week. This may be through a formal agreement with another provider, such as a local hospital. Many practices may have this arrangement for their accreditation purposes. The concern was expressed that services may be receiving this benefit ($95,000 was paid in Tier 1 payments in the NT in 2011) simply through having this arrangement and not in actual delivery of after hours services. Whilst the amounts of the PIP payment are not overly large, some private GP's interviewed indicated that without this payment, they would not be in a position to deliver after hours services.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	The After Hours Program Guidelines indicate that Medicare Locals will implement their Stage Two Plan from 1 July 2013 to ensure continued support for locally appropriate after hours services once existing Australian Government funding arrangements have ceased. Whilst there is no specific requirement that the NTML continue to make these payments on the same terms, it may be preferable that no services are disadvantaged until comprehensive data can be collected by the NTML on after hours service use. <u>General Practice After Hours (GPAH) Grant</u> Currently three services in the NT receive financial support through the GPAH grant scheme, namely the Palmerston Medical Centre ($50,000 – expiring March 2014), the Katherine After Hours Service ($50,000 – expiring 30 June 2013) auspiced through Gorge Health, and the Alice Springs General Practice Clinic Cooperative ($299,090 over two years – expiring 30 June 2013) auspiced through the NTML. The Department of Health and Ageing has confirmed that payment of the grant to the Palmerston Medical Centre will continue to be made by them until March 2014, outside of the After Hours Program Stage 2 funding. The proprietor of the Palmerston Medical Centre indicated to the Project Officer that he would like to continue to offer the after hours service (currently the only bulk billing after hours service in the Palmerston area), post March 2014. The proprietor of Gorge Health indicated to the Project Officer that he intended to continue the service, with the aim of it being a viable service following the expiration of the GPAH grant, and not being reliant on government funding. The service would value continued support from the NTML in terms of promotion and practice support. The Katherine After Hours Service does not currently employ a Nurse, which a further grant may be able to cover. This could allow for an expansion in the service. The proprietor is also currently exploring options to re-locate the service from its current location in the Gorge Health building to stand-alone premises.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	The Alice Springs General Practice Clinic Cooperative currently receives funding through the NTML to operate an after hours clinic located at the Alice Springs Hospital. The clinic operates on a fee-for-service model, with the GPAH grant providing a subsidy if clinic income does not meet expenses. See further discussion below.
Likely ending of current after hours clinic in Alice Springs and the need to develop a service which is accessible, affordable and best meets the needs of the local community	After hours services in Alice Springs are provided through the following means: • Alice Springs Hospital Emergency Department; • Central Australian Aboriginal Congress – operates after hours services until 8 pm on weeknights and on weekends; • Alice Springs Family Medical Practice – provides on-call service; • Other GPs may provide limited on-call services, including home visits for certain patients (e.g. palliative care patients); and • Alice Springs After Hours GP Clinic (known locally as the "ASAP Clinic"). The After Hours GP Clinic is operated by the Alice Springs General Practice Clinic Cooperative (Directors are three local GPs, Principals of their own practices), who collect income through patient fees. Where such fees do not meet the expenses of the clinic, a subsidy is provided by the NTML through the GPAH grant funding. The clinic is currently located in the Outpatients Department at the Alice Springs Hospital (ASH). The NT Government, though the ASH provide significant in-kind support e.g. consumables, security, "peppercorn" rent, estimated at $70,000 per annum. The ASH is currently undergoing renovations, which will limit access to the clinic in its current space. The ASH has indicated to the NTML that they would like the clinic to continue, and that space could be made available within the hospital campus.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	Further negotiations would need to occur at the highest levels of the Department of Health to confirm this arrangement. Two of the three Directors were consulted during the needs assessment process, with both indicating that they would like to conclude their involvement in the service. Other providers in Alice Springs have indicated a willingness to continue to work on a roster-based service, provided arrangements are equitable. Funding under the GPAH grant will expire on 30 June 2013; however, to ensure the legal protection of the three Directors, the service may end prior to 30 June 2013 to ensure that there are adequate funds to cover any winding up expenses.
Limited availability of After Hours Services in Katherine	After hours services in Katherine are provided through the following means: • Katherine Hospital Emergency Department; • Katherine After Hours Service (through Gorge Health) – limited hours; and • Other GPs provide on-call services, including home visits for certain patients (e.g. obstetrics services through the hospital, palliative care patients) The Katherine After Hours Service operates from the Gorge Health premises on Tuesday and Thursday from 7 to 9 pm and Sunday mornings from 10 am to 12 noon. This service operates from a GPAH grant. The proprietor of Gorge Health indicated to the Project Officer that he intended to continue the service, with the aim of it being a viable service following the expiration of the GPAH grant, and not being reliant on government funding. Wurli Wurlinjang operates a clinic in Katherine during standard hours, but does not provide a separate after hours service, with patients referred to the Katherine Hospital after hours. Wurli Wurlinjang has indicated that they may give consideration

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	to providing limited after hours services, if they had the necessary workforce and sufficient funding to provide a sustainable service. Previous discussions with the proprietor of Gorge Health has indicated that attempts were made to attract other Doctors to participate in the roster (including Doctors from Wurli) with no success to date. The Katherine After Hours Service currently operates on a bulk-billing model.
Limited availability of After Hours Services in Tennant Creek other than that provided via the Tennant Creek Hospital emergency department	After Hours services in Tennant Creek are currently provided through the following means: • Tennant Creek Hospital Emergency Department; • On-call service by Anyinginyi Doctors four nights per week to the aged care facility. Standard hours services are currently provided through these agencies, plus the RFDS who operate a fee-for-service GP clinic. Anyinginyi and the RFDS indicated that they were happy with the current arrangements for their patients, and both articulated difficulties in recruiting staff willing to work in the after hours period. During 2005 – 2007, Tennant Creek had no mainstream GP service (aside from Anyinginyi), which may have contributed to a cultural acceptance of use of the Emergency Department for primary health care matters, including after hours services. The RFDS engages two doctors, on a six week on, six week off rotational basis, plus a local Practice Nurse. The RFDS has also recently engaged a Registrar, which has assisted in reducing waiting times for an appointment, from three weeks, to one to two days.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	The three providers appear to maintain productive working relationships with good communication and cooperation indicated by all. Tennant Creek experiences many workforce issues relating to recruitment and retention, amplified by its remoteness and lack of transport options, and the lack of housing for staff. Anyinginyi has recently built units for its doctors and dentists, and is considering a similar program for other health workers. The possibility of services cooperating to provide after hours services outside of the Emergency Department setting was canvassed with the three providers, who indicated a willingness to consider this, and likely service models.
Lack of awareness of after hours services and their use	The NT has a high turnover in the health services workforce, leading to a loss of "corporate knowledge" relating to existing services, both after hours and standard hours. Whilst there are some published directories (notably on the GPNNT web-site) relating to available GP services, this is not currently in an easy-to-navigate format. Lack of knowledge of other local conditions, including weather, family structures and other available/visiting services in the community was also raised during consultations as an area of concern. This may be particularly pertinent where RMPs are based overseas, and may be liaising with staff in remote areas who are also not as familiar with the conditions, due to being locums or short-term agency staff. There is limited information available in the public arena relating to after hours services. Unlike other Medicare Locals, the NTML has no dedicated "After Hours" section on its corporate web-site. Much information is also still on the GPNNT web-site.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	Concerns were also raised relating to the "appropriate" use of services, in both urban and remote areas, with instances described relating to patients requiring emergency treatment attending at their local GP and patients requiring primary health care services attending at the hospital emergency department. The difference in health care services available in urban, regional and remote settings must be considered when promoting "appropriate use" (e.g. in many remote settings only on-call services are available through a clinic and RMP service meaning all medical issues come through this service).
Security for remote health centre staff attending after hours call-outs	*This service was identified during the sub-regional needs assessment conducted during Stage 1 of the Program.* Nurses and other health workers in remote communities have reported feeling physically and culturally unsafe when they undertake after hours on-call work. This may be due to attending unfamiliar areas that are not well-lit (most remote communities have no street lighting), attending areas where there may be unknown or aggressive animals, attending patients who may be mentally unstable, or experiencing violence in the community. Remote Health Centres have limited resources to engage local staff to assist in the after hours period to improve staff and patient safety. Many Remote Health Centres have very small teams which result in staff having to work alone at night, including attending at patient's homes, when called out. This entails attending the clinic, contacting the RMP on call and possibly assisting with a medivac (possibly including assisting in lighting and clearing the air-strip) late at night. Reliance on community volunteers to assist in this process can be problematic, which may therefore increase any safety risks to the actual staff member and or the patient. Remote Health Centre staff generally work very closely with the Police and Night Patrol services to assist in their after hours work. Providing additional staffing at this time, such as through a driver or additional Community Health Worker to assist in liaising with the local community or to assist clinic staff in patient management would ensure the security and safety of remote health centre staff.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
Limited after hours medical services in the Laynhapuy Homelands	*This service was identified during the sub-regional needs assessment conducted during Stage 1 of the Program.* In the After Hours period, people requiring medical assistance from the Laynhapuy homeland communities (approximately 200 kilometre radius South/South West of Nhulunbuy) are encouraged to call the usual Laynhapuy Health Service number which is diverted to the Gove District Hospital and answered by the RMPs on call. In practice, people often contact family in Yirrkala and either ask them to contract the hospital for them, or ask them to contact the Laynhapuy Health Manager at home directly and ask for his assistance. It has been anecdotally reported that this may be in part due to language barriers and a lack of confidence to discuss their issues with health staff they do not know or who they feel does not know their community and their health issues. The result is that in emergency situations, RMPs may err on the side of caution and advise that a patient be brought into the Hospital for assessment or arrange for ambulance or evacuation. This can be costly and may be unnecessary.
Workforce issues – recruitment and retention, and attracting staff to work in the after hours period	The NT experiences difficulties in recruiting and retaining staff. This includes the private, public and ACCHO sectors, and across a range of positions (e.g. Doctor, Nurse, Aboriginal Health Practitioner). The geographic and social isolation experienced in many remote centres, together with housing shortages and other issues (e.g. lack of schools, lack of employment opportunities for partners) compound these shortages. This can lead to over-reliance on a locum and/or “fly-in, fly-out” model. The Tennant Creek Hospital has operated on a locum model (five positions) for the last six years. Other services, including ACCHO and Department of Health remote services, also have Doctors visiting communities for several days at a time. Attracting staff to work in the after hours period was considered to be particularly difficult, with some ACCHO advising that not having to work in the after hours period was considered an “attraction” in recruiting staff. This was also an issue in

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	regional and urban centres. One locum reportedly refused to work in the Katherine After Hours Service. Another Darwin based practice advised that Doctors were not willing to work on the after hours roster, despite it being part of their contractual obligations. Maintaining a "work – life" balance and preventing burn-out was given as the most common reason for this, together with comments that after hours services not generally financially viable. After hours services were referred to by several providers as "a community service."
Issues of remoteness – weather and transport	Many communities are only accessible by the air, including several populous island communities with limited (if any) ferry services. This includes large regional centres such as Nhulunbuy, with the only road access via a 700 km gravel track. Travel between communities can be severely limited by weather and seasonal issues such as heavy rainfall, localized flooding, cyclones and storms which cut road access during the wet season (October – May). Most roads are dry season use only, and many are four wheel drive use only. Island communities are often entirely reliant on barge transport for groceries and other items. Many outstations and homelands have airstrips, but most are not sealed and have no lights for night use. Maintenance of local airstrips generally comes within the remit of Shire Councils; however, if the air-strip is unlit at night, and an evacuation is required, it may be the responsibility of health centre staff to light the runway and/or clear it of any wild-life. In many remote areas, there is minimal telecommunication infrastructure and satellite phones may be required. In places without this infrastructure, emergency responses to critical medical issues may be delayed, and patients may be unable to access ambulance and evacuation services. The lack of universal telecommunication coverage may also result in barriers for people residing in very remote communities to access services such as Health Direct Australia after hour telephone help line. Such difficulties in accessing may be

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	compounded for patients speaking English as a third or fourth language. The NT Department of Health provides support for transport costs via the Patient Assistance Travel Scheme (PATS), which provides a co-payment for NT residents to access a range of specialist services where services not available locally. Patients receive some costs towards their travel and accommodation if they are required to travel more than 200 kilometres. PATS does not provide support for emergency evacuations (that is through Careflight or the Royal Flying Doctor Service) or for routine health screening. As such, the costs of routine health screening, now largely considered as routine in mainstream services (Mammograms for example) is high, and uptake low.
The availability and use of new technologies, such as telemedicine, in the after hours period	The growth of telemedicine in the NT has potential for far-reaching impact on the delivery of health services to remote areas in the NT, including in the After Hours period. Video-conferencing facilities and the use of portable equipment (i.e. ultrasounds) can mean more patients are able to be seen in their home community rather than be required to travel to their nearest regional centre (Telemedicine available for consultations over 15 kilometres). There are issues related to the expansion of telemedicine in the NT, such as the ability for Doctors to bill through Medicare for the service and the availability and usage of the equipment, particularly in the after hours period. In July 2011, Medicare rebates and financial incentives for specialist video consultations were introduced to address some of the barriers to accessing medical services. Telehealth MBS items exist, but these have limitations, including 'Patient-End' Items only being claimable where the Specialist conducting the telehealth consultation is an eligible telehealth service. This may prevent Specialists in the public health sector being able to charge for the service (and therefore the Doctor with the patient also being able to claim through Medicare), and has particular impacts on the use of telehealth in the after hours period. Video conferencing equipment has been installed in several growth communities as an initiative under the National Partnership Agreement between the Northern Territory and Australian Government. Regional hospitals such as Katherine

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	Hospital and Gove District Hospital have comprehensive telehealth equipment. Usage of the equipment is improving but that there could be greater use in a wider range of health presentations and situations if staff felt more confident and encouraged, such as through this direct clinical support. For the after hours period, to access the equipment, patients would be required to attend at a remote health centre (where the equipment is installed and an internet connection established). This may have resultant impacts on security in the clinic and workforce issues. Limitations on technology and the maintenance of stable internet and telephone connections can also be an issue in remote areas.
Possible change in provider to deliver the Palmerston Urgent Care After Hours Service	The Palmerston Urgent Care After Hours Service (PUCAHS) operates from the Palmerston Super Clinic premises at the Palmerston Health Precinct (Darwin urban region). The Palmerston Super Clinic operates a comprehensive service from 8 am to 10 pm, seven days per week through FCD Health. The PUCAHS service operates from 10 pm to 8 am, seven days per week. Prior to October 2012, the PUCAHS service commenced at 6 pm. The Super Clinic service is a fee-for-service, however approximately 60% of patients are bulk-billed, with this number rising to 80% during the extended hours period (6 – 10 pm). PUCAHS is a free service. PUCAHS and Super Clinic staff conduct a hand-over should any patients require service in the cross-over periods. PUCAHS is operated by the NT Government, through agreements with Ochre Health (who supply medical staff) and International SOS (who supply nursing staff). There are separate governance arrangements between the NT Department of Health and Ochre Health, and between the NT Department of Health and International SOS, with separate service agreement.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	Ochre Health's current service agreement is due to expire on 30 April 2013, and it is unknown at the time of preparing this needs assessment report whether this contract will be renewed in the short-term, or whether the service may be put out to tender. The impact of a change in provider for this service is not able to be comprehensively assessed at this time.
Potential impact of the proposed Northern Suburbs GP Super Clinic (proposed for Malak in the Northern Suburbs in Darwin) on local services	The Australian Government made a commitment to build two Super Clinics in the Northern Territory, with funding of up to $5 M being made available to establish one in the Northern suburbs of Darwin (Darwin Urban). However, due to a lack of interest from potential providers, the competitive funding process closed in June 2011 with no applications received. Information available from the Department of Health and Ageing indicates that the process has now moved to a direct funding process. The GP Super Clinics Program does not fund the ongoing service provision for the Clinics. Negotiations were held with the previous NT Government and the Department of Health and Ageing and a site identified in Malak. At the time of finalising this report, the current NT Government's position on the development and operation of the Super Clinic was not able to be ascertained. It is also unknown whether this Super Clinic would operate in the After Hours period, and the extent of its bulk billing policy. This issue was discussed in Northern Territory Parliament on 20 February 2013, with no decisive statement made by the (then) Health Minister on the future location, funding arrangements or selected provider (if any). Responses to the proposed Super Clinic were varied amongst providers (particularly in the Northern Suburbs area) with some indicating that it would have an impact on their patient numbers if it were a bulk billing service, and others considering that any impact could be absorbed. Some providers were not aware of the proposal.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
Access to pharmacy services after hours	Access to pharmacy services in the after hours period varies across the NT, with pharmacists open in the period in Darwin and Alice Springs, but similar services not available in regional and remote areas. Pharmacists deliver vital after hours services, including providing medical advice, information on the management of minor ailments/conditions, filling urgent and non-urgent prescriptions and providing information about medications. Pharmacists are also able to refer people to a GP or other health provider for further assessment or advice.
Lack of consistent data collection on the use of after hours services	*This service was identified during the sub-regional needs assessment conducted during Stage 1 of the Program. It is acknowledged that data collection key issue for many services (both government, ACCHO and private businesses) across the NT.* Collection of baseline after hours service data, ongoing data collection strategies and redevelopment of regional and interagency after hours protocols was identified as a priority area following the sub-regional needs assessment completed in the East Arnhem region in 2012. A well-functioning Clinical and Public Health Advisory Group (CPHAG) operates in the region (auspiced through Miwatj) with attendance by other regional ACCHO and Department of Health representatives. This group is a forum to discuss relevant local issues, including after hours service use. Currently, different data sets are collected across the different agencies relating to after hours service use. The ability to obtain comprehensive, and uniform data sets, would assist in the planning and coordination of after hours services. It could also enable more effective patient journey tracking and play a role in critical incident review, which the CPHAG membership has indicated they see this forum as playing a role in.
Disparity between perceived consumer response to advice	Health Direct Australia operates an after hours telephone helpline across Australia, including in the NT. Callers are triaged by a Nurse, who will refer the patient to a GP (at the call centre) for further phone advice, call an Ambulance, provide self-care

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
from Health Direct Australia when compared with available data	advice or refer them to a local health service (either immediately or within a certain time period). Many providers (particularly in private practice) consulted believed that the majority of callers *were* advised to attend at Emergency Department, either due to lack of clinical training by operators or through the service's fear of potential litigation. Data provided from Health Direct Australia indicates that the majority of callers (51.3%) were recommended to undertake some form of self-care, before seeing a GP. Just under a third of callers (32%) were referred to a medical service (including 19.5% to a Hospital Emergency Department) immediately. It is noted that data provided by Health Direct Australia details the advice given to callers; it is not possible to ascertain which patients followed this advice and/or which patients attended on a service following receipt of this advice. Provider views were mixed on the overall value of the service to patients in the after hours period, with some providers believing it is not the most appropriate use of funding, and that it has not reduced the impact on local services, particularly Hospital Emergency Departments. Other providers felt it was a good complement to their patients, providing assistance and reassurance.
Infrastructure issues: **(i) Katherine Hospital** **(ii) St John Ambulance (Katherine)** **(iii) Endeavour Clinic**	Several providers highlighted infrastructure issues which may affect the delivery of after hours services in the NT. It is noted that several remote clinics will be refurbished/re-developed in 2013. (i) The Katherine Hospital is located within a flood zone, and is amongst one of the first buildings evacuated in the event of a flood. This has resultant impacts on patients, and usual services, including after hours services. No alternate site or plans to re-locate the hospital have been developed or initiated. (ii) The St John Ambulance station in Katherine is located within a flood zone, and is amongst one of the first buildings evacuated in the event of a flood. This has resultant impacts on patients, and usual services, including

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
	after hours services. No alternate site or plans to re-locate the St John Ambulance station have been developed or initiated. (iii) Endeavour Clinic in Nhulunbuy was established with significant backing from the mining company in Nhulunbuy. Today, the mine contributes the clinic building, owns all the significant assets and provides a house and a car for the practice owner. The majority of patients at Endeavour are non-Indigenous, Nhulunbuy residents. However, the clinic has advised that they are space constrained. The space is shared with Community Health, with three Consulting Rooms. The proprietor has advised that this has prevented the Clinic from taking on more Registrars or students and prevents it from operating efficiently when students are present
Government policies **(i) MBS Amount not reflective of services provided, particularly in the After Hours period** **(ii) Impacts of the *Health Professionals and Support Services Award 2010* on wages** **(iii) Government subsidies**	(i) Concern was raised that the amount payable under the MBS was not reflective of services offered by practitioners, particularly in the after hours period, with the view expressed that if this payment was increased, there would be greater incentive to provide after hours services. (ii) Concern was raised relating to the impact of the *Health Professionals and Support Services Award 2010* had on private practices, and their ability to negotiate with administrative staff to work outside standard hours. Administrative staff wages was identified as a key barrier for some practices in providing an after hours service. (iii) Concern was raised over the impact of Government subsided services (e.g. the Super Clinic) on local small business. Concerns were particularly raised relating to the charging of patients by the Super Clinic from 6 – 10 pm

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
and impact on private business	(until October 2012, charges applied from 10 pm).
Future research may be required on the following issues:	There is no clear consensus from practitioners and/or consumers on what After Hours services should provide e.g. extended GP care or emergent care for After Hours (not requiring acute care).
(i) There is no clear consensus from practitioners and/or consumers on what After Hours services should provide	Several regional locations, particularly Tennant Creek, indicated they were currently satisfied with after hours primary health care services being provided by the local public hospital Emergency Department. The lack of clear distinction between what after hours services encompasses e.g. emergency matters or GP-type attendances, and the possible confusion amongst consumers, also leads to a lack of clarity on who may be the best service provider for this care.
(ii) Use of Public Hospital Emergency Departments for Primary Health Care matters, based on historical use and lack of other services	The service model in regional and remote centres may have contributed to the use of hospital Emergency Departments as sources of primary health care. In regional centres there are very limited, if any, providers of after hours care outside the hospital. Due to small workforces compounded by recruitment and retention issues, services during standard hours are often very busy. For a time in Katherine one GP closed their "books" to new patients, and in Tennant Creek patients were waiting up to three weeks for an appointment. The level of overflow from standard hours services naturally has an impact on after hours services. Access to health care after hours in remote communities, whether for an emergency or other health care matter, is though the same mechanism; on-call through the local health centre, with staff members liaising with RMP.

Issue or Gap	Location, outline and description of the issue or gap in after hours primary care
(iii) **There is a limited consumer voice on which settings may be culturally appropriate for Indigenous consumers of After Hours Services**	It was indicated that Hospitals may be more accessible to Indigenous consumers, due to familiarity, potential cultural barriers and cost issues associated with attending a private GP. There is a need to establish this with Indigenous consumers, to assist in service delivery and development.

Chapter 4 - Prioritisation of Gaps

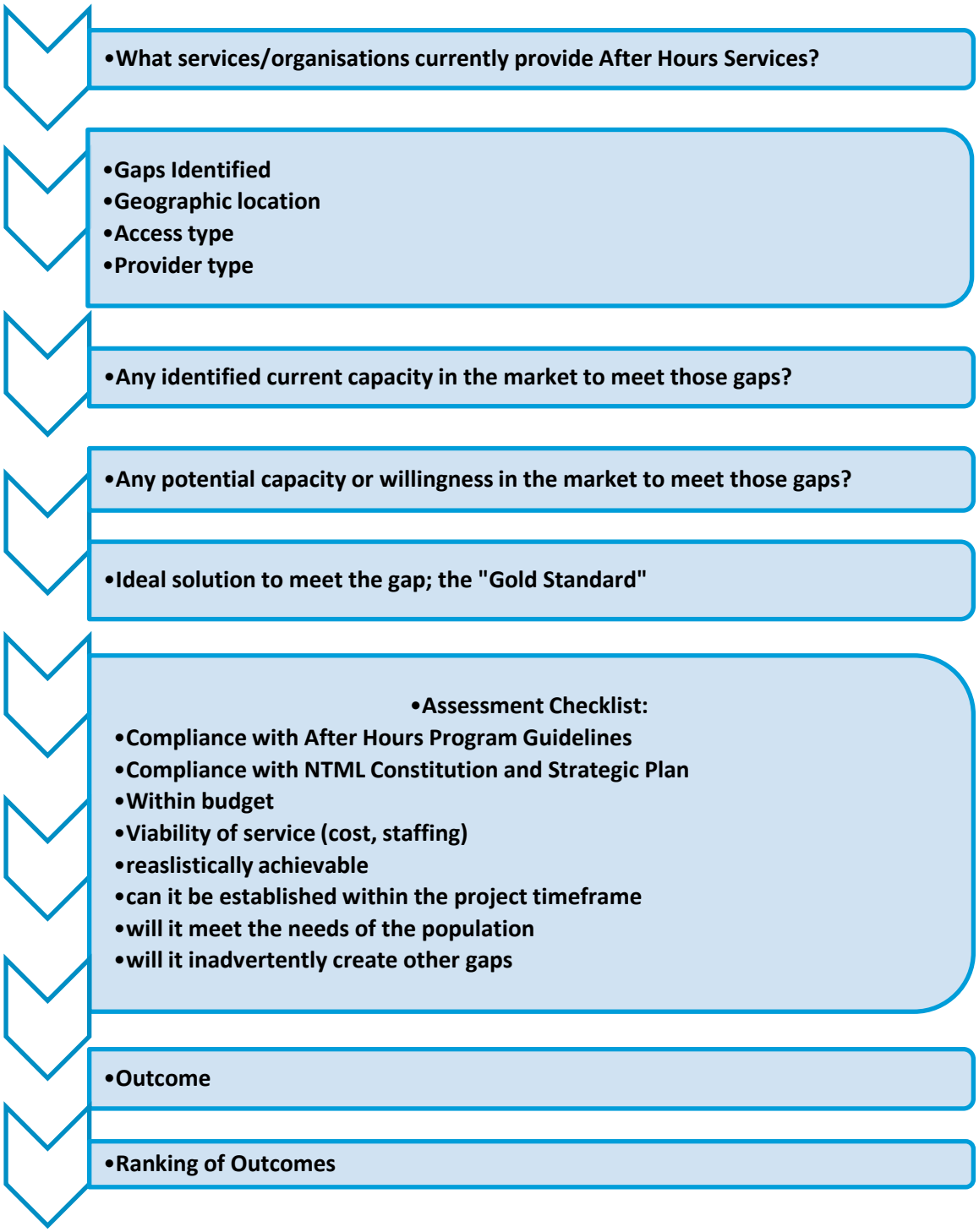
Prioritising: Identifying priority gaps to address access to after hours primary care services in the Northern Territory

4.1 Process and measures used for determining priority gaps

The NTML established a Steering Committee to provide oversight of the Health Needs Assessment being undertaken at the same time. At the Steering Committee's first meeting on 14 December 2012, it was agreed that a Sub Committee would be formed to provide governance and direction in the priority-setting process for the After Hours Project.

The Sub-Committee's membership was drawn from existing members of the Steering Committee, together with additional nominations from the private sector.

A methodology was developed to assess information on services delivering after hours primary health care, together with identified gaps or issues arising, both from a consumer and provider perspective.


•What services/organisations currently provide After Hours Services?
•Gaps Identified
•Geographic location
•Access type
•Provider type
•Any identified current capacity in the market to meet those gaps?
•Any potential capacity or willingness in the market to meet those gaps?
•Ideal solution to meet the gap; the "Gold Standard"
•Assessment Checklist:
•Compliance with After Hours Program Guidelines
•Compliance with NTML Constitution and Strategic Plan
•Within budget
•Viability of service (cost, staffing)
•reaslistically achievable
•can it be established within the project timeframe
•will it meet the needs of the population
•will it inadvertently create other gaps
•Outcome
•Ranking of Outcomes

Refer to Appendix N for further information on the Sub Committee, including membership and Terms of Reference.

The NTML Board also provided feedback and comment on the prioritisation process.

4.2 Prioritised gaps in after hours primary health care services

Priority Rating	Priority Gap	Reason for priority rating	Activity to be carried out to meet priority gap
1	**The availability of future funding for after hours primary health care services post 1 July 2013**	To ensure current providers of after hours services are maintained and to expand the availability of incentive payments to eligible providers	Maintain the current After Hours Practice Incentive Program payments to the 25 services currently receiving this payment. This activity will enable to NTML to collect data on after hours service use and to make an assessment on whether any modifications to the system are required in 2014/15
2	**The availability of future funding for after hours primary health care services post 1 July 2013**	To expand the availability of the incentive payments to additional providers of after hours primary health care, with a particular focus on services in remote and regional areas who meet the eligibility criteria	Expand the current After Hours Practice Incentive Program payment to additional services (who meet the eligibility criteria) with a particular emphasis on regional and remote services. The Palmerston Medical Centre (currently in receipt of a GPAH grant) would also be eligible to receive this payment to ensure a continuity of service beyond March 2014.
3 (a)	**Likely ending of the current dedicated after hours service in Alice Springs and the need to develop a service which is accessible, affordable and best meets the needs of the local community**	To develop an after hours service for Alice Springs which is accessible, affordable and best meets the needs of the local community	Targeted grant available in Alice Springs to develop and implement a sustainable after hours service. This may include an enhancement of existing services.

Priority Rating	Priority Gap	Reason for priority rating	Activity to be carried out to meet priority gap
3 (b)	**Limited availability of After Hours Services in Katherine**	To increase the availability of after hours services in Katherine	Targeted grant available in Katherine to develop and implement a sustainable after hours service. This may include an enhancement of existing services.
3 (c)	**Limited availability of After Hours Services in Tennant Creek**	To develop an after hours service for Tennant Creek which is accessible, affordable and best meets the needs of the local community	Targeted grant available in Tennant Creek to develop and implement a sustainable after hours service. This may include an enhancement of existing services.
4	**Lack of awareness of after hours services and their use – different requirements in urban and regional/remote settings**	To ensure providers and consumers are aware of after hours services available in their community	Develop and distribute resources on available after hours services. Develop and carry-out a community health education campaign on the use of after hours services.
5	**Security for remote health centre staff attending after hours call-outs (focus on East Arnhem)**	To ensure the current arrangements are maintained for a further 12 months	Maintenance of activity funded under Stage 1 of the Program, namely funding for an additional community health worker at the Ngalkanbuy Clinic on Elcho Island to provide additional after hours on-call services.
6	**Limited after hours medical services available in the Laynhapuy Homelands (focus on East Arnhem)**	To ensure the current arrangements are maintained for a further 12 months	Maintenance of activity funded under Stage 1 of the Program, namely funding for additional community health workers at the Birany Birany Outstation and the Dhalinybuy Outstation to provide after hours on-call services

In addition to these projects, the NTML has also identified the need to engage in further analysis on after hours services, including the development and delivery of culturally appropriate models of after hours primary health care services. These activities will be undertaken outside of the funding available for Stage 2 activities.

Chapter 5: The Northern Territory Plan

The Northern Territory Medicare Local's Plan for After Hours Primary Health Care 1 July 2013 – 30 June 2014

In completing this needs assessment and developing the Plan, the NTML aimed to:

- ensure that local after hours primary care services are well planned, coordinated and appropriate to the community's needs;
- ensure that patients are directed to the most appropriate point of care for their condition, wherever they live;
- fund additional services to expand and support after hours service provision;
- provide a smooth and transparent transition to the new funding arrangements, minimising the administrative burden on services; and
- ensure that ongoing evaluation and monitoring of services is undertaken, to ensure provision of the most appropriate, accessible and effective service for patients.

The services recommended for funding in the NT Plan will contribute towards addressing these issues by providing continuity in the type and level of after hours services provided, increasing after hours services in some regions, and contributing towards achieving a more coordinated approach for after hours services and the patient journey through after hours services.

The NTML has recommended that this be achieved through the following actions:

- A continuation of existing After Hours Practice Incentive payment scheme through the NTML. This would ensure that services currently delivering after hours are maintained. It will also enable the NTML to collect data on after hours service use and to make an assessment on whether any modifications to the system are required in 2014/15;
- A limited expansion of the After Hours Practice Incentive Payment to eligible services from January 2014, with a particular emphasis on providers in remote areas;
- In consultation with local providers and the local community, develop and implement service models for after hours service delivery in Alice Springs, Katherine and Tennant Creek, building on existing services where possible;
- Develop and deliver health education campaigns on after hours services, including resources on existing after hours services;
- Continuation of the trial to provide an additional community health worker to provide support for after hours on-call work through the Ngalkanbuy Health Centre on Elcho Island; and
- Continuation of the trial to provide additional community health workers to provide after hours on-call work at the Birany Birany Outstation and Dhalinybuy Outstation.

Refer to Appendix O for a copy of the Plan, as endorsed by the NTML Board.

List of Tables and Figures

Tables

Figures

References

Sources

Australian Institute of Health and Welfare, *Australian Hospital Statistics 2011-2012: Emergency Department Care*, Australian Government, 2012

Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2010-11: State and Territory findings*, 2013

Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework 2010 Report: Northern Territory*, 2011

Australasian College for Emergency Medicine, *Policy on the Australasian Tirage Scale*

Bartlett B and Duncan P, *Top End Aboriginal Health Planning Study: Report to the Top End Regional Indigenous Health Planning Committee of the Northern Territory Aboriginal Health Forum*, 2000

Byron P, Zhao Y, Guthridge SL, Brailsford R, Stacey F, Parkinson J. *Medicare and Pharmaceutical Benefits Scheme Usage Patterns in the Northern Territory 1993/94 to 2003/04*, Northern Territory Department of Health, Health Gains Unit, 2005

Department of the Attorney-General, *Night Patrol Services in the Northern Territory: Operational Framework*, Australian Government, 2010

Department of Health and Ageing, *Medicare Locals - Guidelines for after-hours primary care responsibilities until 30 June 2013,* Australian Government, 2011

East Arnhem Clinical and Public Health Advisory Group, *East Arnhem Region Health Service Delivery Area Health Service Reform Plan*, 2012

Flinders University Northern Territory Rural Clinical School*, Proposal for Nhulunbuy Medical Teaching Clinic*, 2009

General Practice Network of the Northern Territory, *Grant, Incentives and Support for GPs in the NT Factsheet*

General Practice Network of the Northern Territory Workshop Report*, Sustainable General Practice in Aboriginal Primary Health Care in the NT*, 2004

Hughes H, *Indigenous Education 2012*, The Centre for Independent Studies, 2012

Human Capital Alliance, *Framework for the Development of the Primary Health Care Workforce in Aboriginal Health in the Northern Territory*, 2011

Mathers CD and Schofield DJ *The Health Consequences of Unemployment: The Evidence*, Medical Journal of Australia, 1998

Medicare Australia, *Practice Incentive Program – Guidelines,* Medicare Australia, 2011

Medicare Australia, *Practice Incentive Program – After Hours Incentive Guidelines,* Medicare Australia, 2012

Miwatj Health Aboriginal Corporation, *Miwatj Health Aboriginal Corporation: 2011 Business Plan*, 2011

National Health Performance Authority, *Healthy Communities: Australian's experiences with primary health care in 2010–11,* 2013

Northern Territory General Practice Education, *Northern Territory General Practice Education GP Registrar Training Placement Information Guide: 2013*, 2013

Northern Territory Department of Health, *NT Hospitals - Fees and Charges Manual*, Northern Territory Government, 2012

Northern Territory Department of Health, *Patient Assistance Travel Scheme Brochure,* Northern Territory Government, 2008

Northern Territory Department of Health, *Remote Health Atlas*, Northern Territory Government various

Northern Territory Department of Health, *What is a Nurse Practitioner*, Northern Territory Government

Northern Territory Department of Regional Development and Indigenous Advancement, *Major Remote Towns – Update 2012*, 2012

Phillips J, Franklin E, and Viswanathan R, A *Better Way: Building healthy, safe and sustainable communities in the Northern Territory through a community development approach* 2011

Queensland Health, *Social Determinants of Health: Unemployment Fact Sheet*, Southern Public Health Network

Queensland Health, *Social Determinants of Health: Education Fact Sheet*, Southern Public Health Network

Queensland Health, *Social Determinants of Health: Public Health Services Role*, 2002

Royal Australian College of General Practitioners, *Standards for General Practices*, 4th Edition, 2010

Social Health Atlas of Australia, Northern Territory Data, various dates

Relevant Web-Sites Accessed

Australian Bureau of Statistics
http://www.abs.gov.au

Australian Indigenous Health Info Net
http://www.healthinfonet.ecu.edu.au

Department of Health and Ageing:
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/medilocals-ahresp

Medicare Australia
http://www.humanservices.gov.au

Bibliography

Australian Healthcare Associates, *Australian Government Final Evaluation Report: Evaluation of the After Hours Primary Medical Care Program* 2005

Bartlett B, Duncan P, Alexander, D and Hardwick J, *Central Australian Regional Indigenous Health Planning Committee of the NT Aboriginal Health Forum: Central Australian Health Planning Study*, 1997

Finney-Brown M, *Youth Friendly Reproductive Health Services: Young Women in the NT*, Menzies School of Health Research & Monash University, 2012

Havnen O, *Office of the Northern Territory Coordinator-General for Remote Services Report , June 2011 to August 2012*, Office of the Northern Territory Coordinator-General for Remote Services, 2012

McDermott R Dr, *Remote Area Health Services in the Northern Territory: Matching Resources to Needs Australian Rural Health* Research Institute and Menzies School of Health Research, 1995

National Association for Medical Deputising, *After Hours Primary Medical Care Summary Paper: After Hours Medical Care Service in Australia*

National Health Call Centre Network, *Supporting After Hours Primary Health Care through Telehealth*, 2012

Northern Territory Department of Health, *NT Department of Health Annual Report: 2011/2012*, Northern Territory Government, 2012

Northern Territory Department of Health, *A New Service Framework for Health and Hospital Services in the Northern Territory*, Northern Territory Government, 2012

St John Ambulance (NT) Incorporated, *Annual Report 2010-2011*, 2011

Zhao Y, Hanssens P, Byron P, Guthridge S, *Cost Estimates of Primary Health Care Activities for Remote Aboriginal Communities in the NT,* 2006

Appendices

APPENDIX A - SUMMARY OF SERVICE PROVIDER CAPACITY

Service Type	Number of services	Number of services operating during standard hours	Number of services operating in sociable after hours (6 pm – 11 pm)	Number of services operating in unsociable after hours (11 pm - 7 am)	Billing Arrangements e.g. number of services that bulk-bill
Department of Health – Community Health Centres	8	8	Nil	Nil	Free service
Dieticians	4	4	Nil	Nil	Fees payable
Hospitals – Private	1	1	24 hour service	24 hour service	Fees payable Many patients have private health insurance
Hospitals – Public	5	5	24 hour service	24 hour service	Free service
Medical Imaging – stand-alone service	6	6	Nil	Nil	Bulk billing
Occupational Therapy	7	7	Nil	Nil	Fees payable
Pathology Services – stand-alone service	13	13	Nil	Nil	Bulk billing
Pharmacy - stand-alone service	33	33	19	Nil	Fees payable
Physiotherapy	17	17	Nil	Nil	Fees payable
Private General Practice	43	40 (three dedicated after hours services)	9	Nil	7 complete bulk-billing service Most others operate on no routine bulk-billing
Psychiatrists – stand-alone	2	2	Nil	Nil	One bulk-bills

Service Type	Number of services	Number of services operating during standard hours	Number of services operating in sociable after hours (6 pm – 11 pm)	Number of services operating in unsociable after hours (11 pm - 7 am)	Billing Arrangements e.g. number of services that bulk-bill
services					
Psychologists – stand-alone service	33	33	Nil	Nil	Combination of fees payable, employee assistance program and bulk-billing
Remote Health Centres – Aboriginal Community Controlled Health Organisations	38	38	On-call service	On-call service	Free service
Remote Health Centres – Department of Health	54	54	On-call service	On-call service	Free service
Residential Aged Care	16	24 hour service	24 hour service	24 hour service	Mixture of fees and public services
Respite services	1* *Note another to open in 2013	24 hour service	24 hour service	24 hour service	Fees payable
Speech Therapy	5	5	Nil	Nil	Fees payable
Super Clinic	1	1	1	Nil	Fees payable
Urgent Care After Hours Service	1	Nil	1	1	Free service
Podiatrist	5	5	Nil	Nil	Fees payable
Occupational Therapist	7	7	Nil	Nil	Fees payable
Chiropractor	12	12	Nil	Nil	Fees payable
Audiologist	2	2	Nil	Nil	Fees payable

APPENDIX B - TABLE 9: SUMMARY DEMOGRAPHICS - NORTHERN TERRITORY BY REGION

Australian Bureau of Statistics, Census 2011

	Alice Springs Rural		Alice Springs Urban		Barkly		Darwin Rural		Darwin Urban		East Arnhem		Katherine		NT	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Female	7,105	49.9	14,913	51.3	3,238	48.5	8,198	48.2	60,417	47.3	8,226	48.5	9,933	49.2	112,030	48.3
Male	7,138	50.1	14,179	48.7	3,439	51.5	8,797	51.8	67,308	52.7	8,730	51.5	10,241	50.8	119,832	51.7
Aboriginal	11,475	80.6	6,119	21.0	4,315	64.6	12,211	71.9	14,015	11.0	10,733	63.3	10,757	53.3	69,625	30.0
Non-Aboriginal	2,768	19.4	22,973	79.0	,2362	35.4	4,784	28.1	113,710	89.0	6223	36.7	9,417	46.7	162,237	70.0
0 – 4 years	1,385	9.7	2,069	7.1	595	8.9	1,755	10.3	9,261	7.3	1,670	9.8	2,026	10.0	18,761	8.1
5 – 14 years	2,395	16.8	4,043	13.9	1,068	16.0	3,198	18.8	16,972	13.3	3,071	18.1	3,571	17.7	34,318	14.8
15 – 24 years	2,915	20.5	4,094	14.1	1,284	19.2	2,894	17.0	18,378	14.4	2,838	16.7	3,393	16.8	35,796	15.4
25 - 44 years	4,554	32.0	9,469	32.5	1,957	29.3	5,135	30.2	42,538	33.3	5,776	34.1	6,159	30.5	75,588	32.6
45 – 64 years	2,252	15.8	7,302	25.1	1,386	20.8	3,210	18.9	31,464	24.6	3,100	18.3	3,775	18.7	52,489	22.6
65+ years	742	5.2	2115	7.3	387	5.8	803	4.7	9,112	7.1	501	3.0	1,250	6.2	14,910	6.4

APPENDIX C - TABLE 10: IDENTIFIED SUBURBS CONTAINING AREAS WITH A HIGH LEVEL OF DISADVANTAGE

Australian Bureau of Statistics, Census 2011

Suburb	Population	Median Weekly Family Income	Weekly Income - Mortgage %	Weekly Income - Rent %	Average Motor Vehicles %	Total Population Completed Year 12 %	Population aged over 65 years %	Population aged 0 - 4 years %	Median Age	Indigenous %	Born Overseas %	Currently at school %	Unemployed %
Australia	**21,507,719**	**$1,481**	**28.04**	**19.24**	**1.7**	**38.07**	**14.01**	**6.61**	**37**	**2.55**	**24.62**	**30.24**	**5.6**
NT Total	**211,944**	**$1,759**	**27.00**	**12.79**	**1.7**	**29.49**	**5.71**	**8.08**	**31**	**26.79**	**16.60**	**34.50**	**5.3**
Alpurrurulam	442	$608	0.00	9.87	0.8	3.85	2.94	10.86	23	93.89	0.68	21.72	24.0
Amoonguna	274	$487	0.00	5.13	1.1	8.76	4.01	6.57	26	97.45	0.00	37.96	51.3
Araluen	2,695	$2,111	21.87	13.74	1.7	33.14	6.01	8.01	33	14.77	20.70	33.62	2.1
Areyonga	234	$411	0.00	7.30	0.7	3.85	1.28	7.69	23	93.16	0.00	28.21	18.6
Barunga	315	$754	0.00	7.96	1	14.60	3.81	15.24	24	91.43	0.00	25.71	33.0
Batchelor	336	$1,328	21.64	4.14	1.6	20.24	14.58	6.55	44	23.51	9.50	47.62	10.2
Beswick	510	$518	0.00	11.58	0.2	7.45	1.76	12.16	23	97.06	0.00	26.67	18.5
Borroloola	925	$938	0.00	5.33	1.2	11.46	5.19	11.24	26	79.03	2.81	40.97	10.3
Coconut Grove	2,849	$1,637	26.79	19.55	1.3	39.38	9.58	6.39	34	9.79	31.93	30.57	5.4
Daguragu	195	$450	0.00	13.33	0.5	6.67	1.54	14.36	20	97.95	0.00	36.41	6.5
Elliott	343	$875	0.00	7.43	0.8	8.75	8.16	8.16	25	83.38	0.00	38.78	3.7
Emungalan	348	$552	72.46	18.12	0.5	6.90	6.32	5.46	35	83.33	0.00	23.56	33.7
Fannie Bay	2,514	$2,557	22.56	14.86	1.7	46.78	12.77	5.65	40	5.61	21.99	28.68	2.8
Flynn	93	$633	0.00	14.22	1.2	0.00	0.00	16.13	25	96.77	0.00	56.99	0.0

Suburb	Population	Median Weekly Family Income	Weekly Income - Mortgage %	Weekly Income - Rent %	Average Motor Vehicles %	Total Population Completed Year 12 %	Population aged over 65 years %	Population aged 0 - 4 years %	Median Age	Indigenous %	Born Overseas %	Currently at school %	Unemployed %
Galiwinku	2,123	$776	0.00	2.96	0.6	14.08	1.98	12.20	24	89.02	0.47	34.06	11.6
Gapuwiyak	874	$533	4.6	4.69	1.1	6.86	2.06	9.15	24	94.28	0.00	32.95	15.7
Gray	3,310	$1,562	29.55	17.80	1.5	27.07	6.53	8.70	30	15.53	18.10	34.86	5.0
Gunbalanya	1,172	$591	0.00	9.31	0.5	10.41	3.58	8.79	23	88.74	0.00	35.92	15.6
Gunyangara	160	$633	0.00	3.95	1	11.25	3.75	8.75	25	87.50	0.00	30.63	21.0
Hermannsburg	624	$666	0.00	6.01	1.2	12.34	4.49	9.94	24	86.06	0.48	33.33	6.8
Jabiru	1,127	$2,518	0.99	1.43	1.6	33.54	1.33	9.32	33	18.99	17.71	31.06	2.7
Jilkminggan	280	$559	0.00	9.84	0.8	3.57	3.21	14.29	18	97.86	0.00	35.00	0.0
Johnston	81	$759	0.00	7.25	1.9	0.00	3.70	7.41	30	100.00	0.00	17.28	66.7
Kalkarindji	343	$833	0.00	5.04	0.9	12.54	4.96	7.00	27	81.34	0.87	33.82	5.5
Kaltukatjara	295	$210	0.00	11.90	0.8	7.12	6.10	6.44	26	89.49	1.01	35.25	0.0
Katherine South	1,405	$1,476	23.45	13.55	1.4	22.21	8.26	7.19	35	28.75	9.75	35.87	7.5
Kintore	455	$423	0.00	12.53	0.9	6.15	2.86	11.21	23	90.55	0.00	26.15	34.8
Lajamanu	657	$544	0.00	3.68	0.9	9.89	5.02	13.85	21	89.04	0.00	38.51	20.5
Ludmilla	1,719	$1,950	23.67	10.26	1.7	34.15	7.45	6.81	36	19.72	20.23	32.34	4.8
Malak	3,309	$1,830	23.46	11.09	1.8	28.44	6.13	7.98	33	16.53	21.23	39.98	5.0
Maningrida	2,292	$932	0.00	4.83	0.8	14.14	2.27	9.34	24	88.83	0.00	31.68	20.4
Milikapiti	447	$576	0.00	6.94	0.5	8.50	4.70	11.41	28	90.83	0.00	27.29	18.6
Minyerri	484	$756	0.00	7.94	1	14.46	3.10	12.81	19	91.53	1.23	45.04	10.8

Suburb	Population	Median Weekly Family Income	Weekly Income - Mortgage %	Weekly Income - Rent %	Average Motor Vehicles %	Total Population Completed Year 12 %	Population aged over 65 years %	Population aged 0 - 4 years %	Median Age	Indigenous %	Born Overseas %	Currently at school %	Unemployed %
Moulden	3,191	$1,591	28.29	12.57	1.5	18.96	4.61	10.81	28	20.97	11.50	40.27	7.0
Nauiyu	454	$959	0.00	6.47	0.9	8.59	3.30	13.00	23	85.90	1.97	28.85	15.2
Nganmarriyanga	380	$563	0.00	7.10	0.5	17.11	2.37	15.79	20	89.74	1.59	30.53	29.0
Ngukurr	1,057	$736	0.00	10.19	0.7	10.31	3.69	11.45	22	92.05	0.28	34.44	34.1
Nightcliff	3,654	$2,104	22.63	15.68	1.6	43.84	7.85	5.04	37	4.84	29.67	35.60	4.3
Numbulwar	686	$621	0.00	4.03	0.4	10.50	4.52	7.73	26	90.96	0.00	36.01	41.2
Nyirripi	207	$500	0.00	2.00	0.7	18.84	5.80	8.21	25	88.89	0.00	47.83	17.8
Papunya	417	$680	0.00	5.15	0.8	7.91	3.60	11.03	24	89.69	0.00	41.97	23.7
Pirlangimpi	372	$661	0.00	5.45	0.5	13.98	4.03	9.68	31	88.98	0.80	26.34	11.0
Ramingining	834	$439	0.00	20.05	0.4	15.47	2.52	10.67	27	91.73	0.00	32.25	43.1
Santa Teresa	554	$574	0.00	3.48	0.7	11.01	3.25	9.93	24	90.61	0.00	35.02	8.6
Stuart	556	$1,518	35.18	13.83	1.8	22.12	6.65	9.71	31	51.26	8.14	23.74	7.2
Tennant Creek	3,060	$1,411	16.36	8.50	1.5	19.51	6.63	8.59	32	51.99	10.29	37.35	7.0
Timber Creek	231	$1,531	0.00	1.31	1.5	12.12	7.79	9.52	30	64.9	3.85	28.5	6.2
Wadeye	2,111	$450	0.00	11.11	0.5	20.61	2.37	13.50	21	91.28	0.0	30.6	2.3
Warruwi	425	$906	0.00	8.28	0.4	11.53	2.12	11.76	17	93.88	0.0	36.24	27.2
Wurrumiyanga	1,528	$569	28.59	7.03	0.5	14.40	2.29	7.53	26	88.29	0.0	33.77	5.0
Yirrkala	843	$1,174	0.00	3.41	1.1	14.12	3.20	8.19	27	76.99	0.36	34.99	5.5
Yuelamu	208	$518	0.00	3.86	0.8	7.21	4.33	10.58	28	90.87	0.0	33.65	0.0

Suburb	Population	Median Weekly Family Income	Weekly Income - Mortgage %	Weekly Income - Rent %	Average Motor Vehicles %	Total Population Completed Year 12 %	Population aged over 65 years %	Population aged 0 - 4 years %	Median Age	Indigenous %	Born Overseas %	Currently at school %	Unemployed %
Yuendumu	688	$684	0.00	3.65	0.9	11.05	5.67	10.47	25	85.32	0.44	31.1	24.7

APPENDIX D - TABLE 11: NUMBER OF PEOPLE ESTIMATED TO SUFFER FROM CHRONIC HEALTH CONDITIONS IN THE NT

Australian Bureau of Statistics, Australian Health Survey 2011-2012

Selected Health Characteristics (Estimate)		2007–08	2011-12
High/Very high psychological distress		N/A	11,200
Selected Long Term Conditions	Arthritis	N/A	15,800
	Asthma	N/A	15,000
	Back pain/problem, disc disorder	N/A	20,200
	Chronic obstructive pulmonary disease	N/A	2,300
	Deafness	N/A	15,300
	Diabetes mellitus	N/A	6,500
	Hay fever and allergic rhinitis	N/A	21,200
	Heart, stroke and vascular disease	N/A	5,100
	Hypertensive disease	N/A	11,100
	Kidney disease	N/A	1,000
	Long sightedness	N/A	40,700
	Malignant neoplasm (cancer)	N/A	3,000
	Mental and behavioural problems	N/A	17,600
	Osteoporosis	N/A	3,500
	Short sightedness	N/A	30,700
Current long-term condition is a result of an injury		N/A	16,100
Lifestyle risk factors	Overweight or Obese Body Mass Index	N/A	63,400
	Current daily smoker	N/A	29,600
	Alcohol consumption under the 2001 National Health and Medical Research Council Guidelines: Longer term risk - Risky/High risk consumption	N/A	18,700
	Alcohol consumption under the 2001 National Health and Medical Research Council	N/A	62,400

Selected Health Characteristics (Estimate)		2007–08	2011-12
	Guidelines: Short term risk - Risky/High risk consumption		
	Alcohol consumption under the 2009 National Health and Medical Research Council Guidelines: Exceeded lifetime risk guidelines	N/A	30,700
	Alcohol consumption under the 2009 National Health and Medical Research Council Guidelines: Exceeded single occasion risk guidelines	N/A	67,800
	Inadequate fruit or vegetable consumption	N/A	119,500
	Sedentary/Low exercise level	N/A	82,800
	Total persons	**N/A**	**166,100**

APPENDIX E - TABLE 12: PERCENTAGE OF CHILDREN ASSESSED AS DEVELOPMENTALLY VULNERABLE IN THE AUSTRALIAN EARLY CHILDHOOD DEVELOPMENT INDEX DOMAINS

Social Health Atlas of Australia, Northern Territory (SLA and LGA) – Early childhood Development: Australian Early Childhood Development Index, 2009

	Percentage children assessed as developmentally vulnerable against the Australian Early Childhood Development Index domains						
	One or more domains %	Two or more domains %	Physical Health and wellbeing %	Social competence %	Emotional maturity %	Language and cognitive skills (schools-based) %	Communication skills and general knowledge %
Australia	23.6	11.9	9.4	9.5	8.9	8.9	9.2
Total NT	40.7	25.9	20.1	19.5	15.9	24.3	20.3
Alice Springs Rural	81.2	67.2	54.1	44.8	35.7	64.5	58.9
Alice Springs Urban	29.6	15.7	12.6	11.5	12.9	15.4	10.9
Barkly	68.9	52.4	42.1	39.4	30.2	49.2	44.5
Darwin Rural	69.3	47.4	49.3	36.2	35.5	38.3	27.5
Darwin Urban	25.3	12.3	10.7	11.3	9.0	10.5	8.7
East Arnhem	41.0	27.0	17.5	16.9	19.6	19.4	19.3
Katherine	64.4	45.4	28.1	31.6	21.2	48.1	38.8

APPENDIX F - TABLE 13: ESTIMATED PREVALENCE OF SMOKING DURING PREGNANCY – NORTHERN TERRITORY, 2006-2008

Social Health Atlas of Australia, Northern Territory (SLA and LGA) – Estimated prevalence of smoking during pregnancy

	Numerator	Denominator	%
Australia*	70,627	469,875	15.0
Total NT	2,991	10,938	27.3
Alice Springs Rural	168	666	25.3
Alice Springs Urban	311	1,254	24.8
Barkly	123	413	29.7
Darwin Rural	290	640	45.3
Darwin Urban	1,171	5,708	20.5
East Arnhem	354	806	44.0
Katherine	574	1,451	39.6

*Note – Australian figure excludes data from Victoria and Queensland.

APPENDIX G - TABLE 14: IMMUNISATION STATUS OF CHILDREN, SEPTEMBER 2008

Social Health Atlas of Australia, Northern Territory (SLA and LGA), Immunisation Status of Children

	Numerator	Denominator	%
Australia	68,386	74,931	91.3
Total NT	831	920	90.3
Alice Springs Rural	36	42	86.3
Alice Springs Urban	99	120	82.5
Barkly	34	36	93.7
Darwin Rural	41	46	89.2
Darwin Urban	472	515	91.7
East Arnhem	55	61	90.2
Katherine	94	100	94.0

APPENDIX H - TABLE 15: MEDICARE BENEFIT STATISTICS – NON-REFERRED ATTENDANCES – NT

Medicare Australia, Divisions of General Practice Statistics, Northern Territory Division of General Practice, MBS Non-Referred Attendances

Service Type		2009-10	2010-11	2011-12
General Practitioner and other non-referred attendances	Number of Services	579,077	600,781	636,073
	Benefit Paid ($'000)	23,126	24,703	26,765
	Fee Charged ($'000)	29,694	31,771	33,866
PIP Incentive related Services	Number of Services	1,870	1,816	1,914
	Benefit Paid ($'000)	116	118	120
	Fee Charged ($'000)	129	131	136
Health Assessment	Number of Services	10,369	13,111	15,714
	Benefit Paid ($'000)	1,944	2,562	3,118
	Fee Charged ($'000)	1,944	2,562	3,119
Mental Health Services	Number of Services	8,228	9,072	9,650
	Benefit Paid ($'000)	890	966	869
	Fee Charged ($'000)	927	1,006	914
After Hour Services	Number of Services	24,389	25,692	26,676
	Benefit Paid ($'000)	1,296	1,382	1,450
	Fee Charged	1,618	1,715	1,714

Service Type		2009-10	2010-11	2011-12
	($'000)			
Chronic Disease Related Services	Number of Services	15,920	19,163	24,382
	Benefit Paid ($'000)	1,658	2,058	2,637
	Fee Charged ($'000)	1,661	2,064	2,643
Other	Number of Services	2,731	2,484	2,018
	Benefit Paid ($'000)	356	345	355
	Fee Charged ($'000)	449	398	363

APPENDIX I - TABLE 16: NT SUMMARY – GP WORKFORCE GENDER SPLIT

Northern Territory Medicare Local Profile Report, 2013

		2009-10	2010-11	2011-12
Female	**Head Count**	192	220	235
	Full Time Equivalent	54	56	60
	Full-time Workload Equivalent	54	56	62
Male	**Head Count**	221	243	244
	Full Time Equivalent	67	72	72
	Full-time Workload Equivalent	72	77	80

APPENDIX J – SUMMARY - LOCAL FACTORS AFFECTING HEALTH – REGIONAL BREAK-DOWN

Urban Areas

In the two major urban centres, Darwin (including Palmerston and Greater Darwin) and Alice Springs, there is generally good access to primary health care services, which is largely based on the GP and Medicare-based fee-for-service funding model.

Major urban areas are less affected by adverse weather conditions, with generally reliable road and air access.

- *Population Mobility:*
  The Indigenous population is highly mobile, with complex inter-linked kinship and landownership, and frequent movement between communities occurs to maintain family connections and take part in ceremonies.

  As major service and tourism centres, Darwin and Alice Springs population fluctuations also occur due to workforce issues and tourism.

- *Substance misuse:*
  Substance misuse, including alcohol, petrol and other illicit drugs, is a huge health concern across the NT. Night patrol services (and a day patrol service in Darwin) currently operates in Darwin and Alice Springs.[88] There are residential rehabilitation facilities available, including those specifically for Aboriginal people and their families. Other support programs are run by a variety of NGOs, such as Catholic Care NT and the Salvation Army.

- *Mental Health:*
  Mental health services, both in-hospital and outreach services, are available in Darwin and Alice Springs through the Department of Health.

  Aboriginal Community Controlled Health Organisations (ACCHO) in Darwin and Alice Springs have "Emotional, Social and Wellbeing Units" which provide counselling and other support services. Several agencies (such as the Top End Mental Health Consumers Organisation and the Mental Health Association of Central Australia etc.) provide case management services, including recreation activities, life support and education programs. Many other NGOs also offer counselling and other emotional support programs.

- *Aged and Disability care:*
  Private and public aged care facilities are available in Darwin, with public services available in Alice Springs.

[88] The two Darwin based services will cease operation as of 1 July 2013, with these services to be provided by the Northern Territory Police. http://www.abc.net.au/local/stories/2012/12/06/3648959.htm

The Department of Health provides coordination for Aged and Disability Care Teams, partnering with the Australian government, local councils, advocates and private providers to provide services for adults and children. The Department provides and funds services such as "assessment and therapy, case management, respite, supported accommodation and care, community access, information and training, licensing and standards, equipment and subsidies, monitoring and evaluation and guardianship."[89]

Regional Centres

The regional centres of Katherine, Tennant Creek and Nhulunbuy experience a range of issues similar to those in both urban and remote areas. Generally less vulnerable to adverse weather conditions than remote areas (although the Hospital and St John Ambulance station in Katherine are presently located in flood zones and are two of the first buildings to be evacuated in the event of a flood), regional centres experience a range of issues associated with reduced access to services.

In all three regional centres there are General Practitioners, ACCHO and NT Government Community Health Centres providing primary health care services during standard hours. Patients in regional centres requiring after hours services are generally directed to their nearest hospital, with Katherine currently the only centre with a separate after hours GP service[90].

In addition to issues of population mobility, weather and infrastructure, specific issues affecting the health status of populations in these regional centres include:

- *Substance misuse:*
  Night patrol services currently operate in over 80 communities across the NT[91], including Katherine, Tennant Creek and Nhulunbuy. Sobering up Shelters are available in these centres, together with small residential rehabilitation services, run by a combination of local associations and NT Government.

  Specialist teams, within the NT Department of Health, are generally located in major urban and regional centres, and have capacity to provide support to communities and deliver some clinical services.

- *Mental Health:*
  Regional centres have access to visiting services and telephone based mental health triage services, operating from Darwin and Alice Springs.

- *Aged care:*
  Katherine and Tennant Creek have public aged care facilities. However, there is no aged care facility in Nhulunbuy, with the closest Residential Aged Care Facilities being in Katherine and

[89] http://www.health.nt.gov.au/Aged_and_Disability/
[90] The Katherine After Hours Service operating from 7 pm to 9 pm on Tuesday and Thursday and 10 am to 12 noon on Sundays.
[91] Department of the Attorney-General, *Night Patrol Services in the Northern Territory: Operational Framework*, Australian Government, 2010

Darwin, 700 km away. There are two short-term respite beds available at Gove District Hospital.

The Department of Health Aged and Disability Service provides services Territory-wide, from offices located in Alice Springs, Tennant Creek, Katherine, Nhulunbuy and Darwin, and can also provide outreach services to all parts of the Territory.[92]

- *Availability of Accommodation for staff:*
  The availability and price of staff accommodation is a major issue in regional communities across the NT. This issue can hamper the expansion of health and other services, and can result in over-reliance of a "Fly-in, Fly out" workforce. For example, Nhulunbuy is a closed lease and average rental for a t two or three bedroom house is up to $1,000 per week.

Remote Areas

In the majority of remote areas in the NT, the primary health care system is not based on a GP and Medicare-based fee-for-service funding model.

A significant proportion of primary health care services are provided by nurses, Aboriginal Health Practitioners (formerly known as Aboriginal Health Workers) and allied health professionals, whose services are generally non-Medicare refundable. Other comprehensive primary health care services - particularly population health and promotion services - are not refundable under Medicare. Even where Medicare services are claimable, the actual costs of delivering services in a remote area are much higher than in urban or rural settings and the refunded benefit does not reflect the actual cost of service delivery.

Doctors are located in some larger remote communities, but most operate on a fly-in, fly-out model, as do specialists and other allied health providers. Many patients are required to travel to hospitals to undergo assessments and receive treatment due to a lack of facilities in communities.

Other factors impacting on health services in remote settings include:

- *Population Mobility:*
  The Indigenous population is highly mobile, with complex inter-linked kinship and landownership, and frequent movement between communities occurs to maintain family connections and take part in ceremonies. The population may also be dispersed due to living in out-stations and homelands for family, cultural and social reasons, meaning long distances to travel to access health services;

- *Monsoonal weather*
  Travel between communities can be severely limited by weather and seasonal issues such as heavy rainfall, localized flooding, cyclones and storms which cut road access in the wet

[92] http://www.health.nt.gov.au/Aged_and_Disability/

season (October to May). Most roads are dry season use only, and many are four wheel drive use only. Island communities are often entirely reliant on barge transport for groceries and other items.

- *Transport issues/Distances*

  Many communities are only accessible by the air, including several populous island communities with limited (if any, ferry service).

  Many remote communities, including outstations and homelands have airstrips, but some are not sealed and have no lights for night use. Maintenance of local airstrips generally comes within the remit of Shire Councils; however, if the airstrip is unlit at night, and an evacuation is required, it may be the responsibility of health centre staff to light the runway and/or clear it of any wildlife.[93]

  The NT Department of Health provides support for transport costs via the Patient Assistance Travel Scheme (PATS), which provides a co-payment for NT residents to "access a range of essential specialist medical/surgical services where services are not available locally or from a visiting service."[94] Patients will receive some costs towards their travel and accommodation they are required to travel more than 200 kilometres.[95] PATS does not provide support for emergency evacuations (that is through Careflight or the Royal Flying Doctor Service) or for routine health screening. As such, the cost of routine health screening (e.g. Mammograms) is high, and uptake low.

- *Telecommunications*

  In many remote areas, there is minimal telecommunication infrastructure and satellite phones may be required. In places without this infrastructure, emergency responses to critical medical issues can be delayed, and patients may be unable to access ambulance and evacuation services.

  The lack of universal telecommunication coverage may also result in barriers for people residing in very remote communities to access services such as Health Direct Australia after hours telephone help line. Such difficulties in accessing can be compounded for patients speaking English as a third or fourth language.

- *Substance misuse:*

  Substance misuse, including alcohol, petrol and other illicit drugs, is a huge health concern across remote communities. Night patrol services currently operate in over 80 communities in the NT.[96] However there is a lack of dedicated rehabilitation services, including residential rehabilitation operating outside the major urban and regional centres. Some communities

[93] Department of Health Remote Health Atlas, http://www.health.nt.gov.au/Remote_Health_Atlas/index.aspx
[94] Northern Territory Department of Health, *Patient Assistance Travel Scheme Brochure,* Northern Territory Government 2008
[95] Ibid
[96] Department of the Attorney-General, *Night Patrol Services in the Northern Territory: Operational Framework*, Australian Government, 2010

have community managed outstation programs such as the Mt Theo Outstation Cultural Respite and Rehabilitation Program started by the people of Yuendumu. New funding under the Stronger Futures package will employ specialist community based workers to provide alcohol and other drug treatment in 20 communities, to help support local Alcohol Management Plans.

Specialist teams, within the NT Department of Health, are generally located in major urban and regional centres, and have capacity to provide support to communities and deliver some clinical services.

- *Mental Health:*
  Mental health issues and management of mental health conditions is a huge concern across remote communities. Smaller communities may receive largely visiting mental health services, with each community receiving on average a visit by a case manager every four weeks and a Registrar or Consultant visit every three months. Limited Child and Adolescent overnight visits are provided in certain areas. Other communities have community based mental health workers, and Aboriginal Mental Health Workers.

  The management and evacuation of patients suffering from mental health issues, particularly psychotic episodes, can be particularly challenging for staff at remote health centres, with the Remote Health Atlas and CARPA Manual providing guidance.

- *Aged and Disability Care:*
  Smaller communities may often have limited aged care services for residents, generally managed by the Shire Council. For example, the Central Desert Shire Council runs programs for the "aged and disabled old people and young people as identified across the communities of Lajamanu, Nyirripi, Yuelamu, Laramba Ti-Tree and Wilora."[97] Services available in communities may be limited to day programs, including provision of meals, showering and recreational programs. Other communities such as Docker River have a small number of residential aged care places.

  Other remote centres may have limited or no access to aged care services. For example, in the East Arnhem region, there is no aged care facility in Yirrkala or Nhulunbuy, with the closest Residential Aged Care Facilities being in Katherine and Darwin, 700 km away. However, there are two short-term respite beds available at Gove District Hospital.

- *Availability of Accommodation for staff:*
  The availability of staff accommodation is a major issue in remote communities across the NT. This issue can hamper the expansion of health and other services, and can result on over-reliance of a "Fly-in, Fly out" workforce.

  Health staff housing in remote communities is limited and there is insufficient housing for the Indigenous residents, so it is difficult to obtain vacant housing for additional health staff.

[97] http://centraldesert.nt.gov.au/aged-care

This has consequent impacts on recruitment and retention. Visitor accommodation exists in most major communities however it is also limited and inappropriate for medium to long term stays. In regional centres, accommodation may be available but extremely expensive. For example, Nhulunbuy is a closed lease and average rental is up to $1,000 per week for a modest two or three bedroom house.

- *Machado Josephs Disease:*
  A unique health issue impacting some communities in the East Arnhem region is the hereditary neuro-degenerative condition Machodo Josephs Disease (MJD). "MJD is an inherited, autosomal dominant disorder, meaning that each child of a person who carries the defective gene has a 50% chance of developing the disease. In addition the mutation is typically expanded when it is passed to the next generation…this means that symptoms of the disease appear around 8-10 years earlier and are more severe…Progression to dependence occurs over 5 to 10 years and most people are wheelchair bound and fully dependent for activities of daily living within 10-15 years of the first symptoms emerging"[98]. There is no known cure for MJD.

  There are people living with MJD across the East Arnhem region although mostly in Angurugu and Umbukumba, Milyakburra, Yirrkala, Galiwin'ku, Numbulwar, and some outstations and homelands.

[98] Machado Josephs Foundation website http://www.mjd.org.au/2-what-is-mjd.html

APPENDIX K - AUSTRALASIAN COLLEGE OF EMERGENCY MEDICINE – AUSTRALASIAN TRIAGE SCALE

Australasian College for Emergency Medicine
ABN 76 009 090 715

POLICY ON
THE AUSTRALASIAN TRIAGE SCALE

1. INTRODUCTION

The Australasian Triage Scale (ATS) is designed for use in hospital-based emergency services throughout Australia and New Zealand. It is a scale for rating clinical urgency. Although primarily a clinical tool for ensuring that patients are seen in a timely manner, commensurate with their clinical urgency, the ATS is also a useful casemix measure. The scale directly relates triage code with a range of outcome measures (inpatient length of stay, ICU admission, mortality rate) and resource consumption (staff time, cost). It provides an opportunity for analysis of a number of performance parameters in the Emergency Department (casemix, operational efficiency, utilisation review, outcome effectiveness and cost).

2. PRACTICALITY AND REPRODUCIBILITY

As the ATS is a primarily clinical tool, the practicalities of patient flow must be balanced with attempts to maximise inter-rater reproducibility. It is recognised that no casemix measure reaches perfect reproducibility. Reproducibility within and between emergency departments can be maximised by application of the Guidelines for Implementation and widespread use of the training package.

Triage accuracy and system evaluation can be assessed by comparison against guidelines. Patterns of triage category distribution, ICU admission and mortality by triage category should be comparable between peer hospitals of similar role delineation. Admission rate by triage category is also a useful comparison between peer hospitals for the higher urgency categories. These benchmarks for Emergency Departments of different role delineation should be reviewed from time to time as disposition practices change.

Standards of consistency should also be regularly checked with studies of inter-rater reliability. An acceptable standard of inter-rater agreement is represented by a weighted Kappa Statistic of at least 0.6.

3. APPLICATION

3.1 Procedure

All patients presenting to an Emergency Department should be triaged on arrival by a specifically trained and experienced registered nurse. The triage assessment and ATS code allocated must be recorded. The triage nurse should ensure continuous reassessment of patients who remain waiting, and, if the clinical features change, re-triage the patient accordingly. The triage nurse may also initiate appropriate investigations or initial management according to organisational guidelines.

The triage nurse applies an ATS category in response to the question: *"This patient should wait for medical assessment and treatment no longer than...."*

34 Jeffcott Street • West Melbourne • Victoria 3003 • Australia • Telephone: (03) 9320 0444 • Fax: (03) 9320 0400

3.2 Environmental and Equipment Requirements

The triage area must be immediately accessible and clearly sign-posted. Its size and design must allow for patient examination, privacy and visual access to the entrance and waiting areas, as well as for staff security.

The area should be equipped with emergency equipment, facilities for standard precautions (hand-washing facilities, gloves), security measures (duress alarms or ready access to security assistance), adequate communications devices (telephone and/or intercom etc) and facilities for recording triage information.

4. DESCRIPTION OF SCALE

ATS CATEGORY	TREATMENT ACUITY (Maximum waiting time)	PERFORMANCE INDICATOR THRESHOLD
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

5. PERFORMANCE INDICATOR THRESHOLDS

The indicator threshold represents the percentage of patients assigned Triage Code 1 through to 5 who commence medical assessment and treatment within the relevant waiting time from their time of arrival. Staff and other resources should be deployed so that thresholds are achieved progressively from ATS Categories 1 through to 5. The performance indicator thresholds shown are appropriate for the period 1998 – 2002 inclusive[1], and should be achievable in all Emergency Departments. Performance indicator thresholds must be kept under regular review.

Where Emergency Department resources are chronically restricted, or during periods of transient patient overload, staff should be deployed so that performance is maintained in the more urgent categories.

It is neither clinically nor ethically acceptable to routinely expect any patient or group of patients to wait longer than two (2) hours for medical attention. Prolonged waiting times for undifferentiated patients presenting for emergency care is viewed as a failure of both access and quality.

6. QUALITY ASSURANCE

Triage accuracy and system evaluation may be undertaken in part by reviewing the triage allocation against guidelines, triage category "footprint" of example diagnoses, average waiting time, admission rates and mortality rates in each triage category with peer hospitals. As practices such as disposition change over time, these benchmarks should be periodically reviewed.

7. REFERENCE

Commonwealth Department of Health and Family Services, Coopers and Lybrand Consultants. Development of Agreed Set of National Access Performance Indicators for: Elective Surgery, Emergency Departments and Outpatient Services. Canberra, July 1997, p106.

P06 Reviewed March 2006 (no changes made)
Revised November 2000
Adopted by Council November 1993

APPENDIX L - HEALTH DIRECT AUSTRALIA – CLASSIFICATION GUIDELINES USED BY TRIAGE NURSES FOR PATIENTS IN THE NORTHERN TERRITORY

PATIENT GUIDELINE
Abdominal Pain / Discomfort
Cough (Paediatric)
Nausea / Vomiting
Rash / Hives / Eruptions
Abortion <20 Weeks-Threatened/Spontaneous
Headache
Diarrhoea / Change in Bowel Habits
Chest Pain / Discomfort
Fever (Paediatric)
Postoperative Problems
Cough - Adult
GI Bleeding
Diarrhoea (Paediatric)
Back Symptoms - Upper / Lower
Bloody Urine (Haematuria)
Vomiting (Paediatric)
Flank Pain
Dizziness / Vertigo
Croup (Paediatric)
Sore Throat / Hoarseness
Urinary Symptoms - Female
Colds (Paediatric)
Earache (Paediatric)
Vaginal Bleeding (Premenopausal) - Abnormal
Skin Lesions / Skin Irritation
Neurological Symptoms / TIA
Breathing Problems
Flu-Like Symptoms
Ear - Pain/Injury/Foreign Body
Tooth, Gum and Jaw Symptoms
Hives (Paediatric)
Abdominal Pain, Pregnant >20 Weeks

Lower Leg Non-Injury
Vaginal Discharge / Irritation
Stools, Blood in (Paediatric)
Burns
Diabetes: Out of Control
Ear Infection Follow-Up Call (Paediatric)
Allergic Reaction Severe; Known / Suspected
Knee Non-Injury
Abdominal Pain - Male (Paediatric)
Rashes - Widespread, on Drugs (Paediatric)
Wound Infection
Bites - Animal / Human
Constipation (Paediatric)
Urinary Symptoms / Prostate Problems
Rashes, Widespread, Cause Unknown (Paediatric)
Abrasions/Lacerations/Puncture Wounds.
Abdominal Pain - Female (Paediatric)
Eye Infection / Irritation
Eye Injury / UV Light Exposure
Postpartum - Common Problems
Nosebleed - With and Without Injury
Foot Non-Injury
Ear Discharge (Paediatric)
Immunisation Reactions (Paediatric)
Urination, Pain - Female (Paediatric)
Asthma Attack
Asthma Attack (Paediatric)
Breast Symptoms - Postpartum
Abortion--Therapeutic/Elective; Sx Post
Thigh Non-Injury
Palpitations/Irregular Heartbeat
Sore Throat (Paediatric)
Shoulder Non-Injury
Foot Injury
Impetigo (Paediatric)
Bites and Stings - Insects / Spiders
Eye Condition - No Injury / Vision Change

Toe / Toenail Injury
Bite, Animal or Human (Paediatric)
Adult Fever
Head Injury
Urination, Pain - Male (Paediatric)
Skin, Swelling of (Paediatric)
Rashes, Localised, Cause Unknown (Paediatric)
Wound Infection (Paediatric)
Nausea / Vomiting, Pregnant
Headache (Paediatric)
Wheezing - Other than Asthma (Paediatric)
Eye - with Pus (Bacterial) (Paediatric)
Knee Injury
Nappy Rash (Paediatric)
Failure on Antibiotics (Paediatric)
Neck Pain (Paediatric)
Diarrhoea on Antibiotics (Paediatric)
Constipation / Rectal Symptoms
Crying Child > 3 months (Paediatric)
Electric Shock
Hand Non-Injury
Breathing Difficulty - Severe (Paediatric)
Eye - Red without Pus (Paediatric)
Chest pain >8 hours
Rash, Amoxycillin (Paediatric)
Eye, Swelling of (Paediatric)
Bites and Stings - Insects / Spiders (Paediatric)
Penis Problems / Sexual Problems
Confusion / Disorientation / Agitation
Trauma - Head (Paediatric)
IUD; Symptoms
Penis - Scrotum Symptoms (Paediatric)
Ankle Non-Injury
Genital Lesions - Female
Crying Baby Under 3 mo (Paediatric)
Sores (Paediatric)
Toothache (Paediatric)

Fainting
Ear - Hearing Symptoms
Cast Splint Problem
Leg Pain (Paediatric)
Immunisation Reactions
Hip Non-Injury
Anxiety: Mild to Moderate
Foetal Movement - Decreased, Pregnant
Ear - Pulling at (Paediatric)
Ear, Swimmer's (Paediatric)
Tremor
Urine, Blood in (Paediatric)
Neck Pain or Injury
Postoperative Problems Paediatric
Oral Contraceptive Pills; Symptoms/Info
Worms (Paediatric)
Nosebleed (Paediatric)
Shoulder Injury
Finger / Fingernail Injury
Fluid Intake Decreased (Paediatric)
Stools, Unusual Colour of (Paediatric)
Fifth Disease (Paediatric)
Swallowed Foreign Body (Paediatric)
Diabetes: GI Problems
Medication Question Encounters Adult
Foot or Ankle, Swelling of (Paediatric)
Vaginal Bleeding and >20 Weeks Gestation
Chickenpox (Paediatric)
Hand-Foot-Mouth Disease (Paediatric)
Chest Pain (Paediatric)
Strep Throat Follow-Up Call (Paediatric)
Seen Doctor/Health Care Provider
Dizziness (Paediatric)
Anxiety: Severe / Panic
Eye - Foreign Body in (Paediatric)
Face, Swelling of (Paediatric)
Upper Respiratory Tract Infections / Colds

Diabetes: Foot Problems
Trauma - Leg (Paediatric)
Cast Splint Problem (Paediatric)
Face Pain / Swelling - No Injury
Weakness / Paralysis
Vaginal Itching/Irritation (Paediatric)
Neck Lump / Swelling
No Guideline Available (Adult)
Vaginal Foreign Body; Known / Suspected
Back Symptoms, Pregnant
Abrasions/Lacerations/Bites/Puncture Wounds (Paediatric)
Vomiting When Taking Medications (Paediatric)
Lymph Nodes, Swollen (Paediatric)
Mouth Ulcers (Paediatric)
Toe / Toenail Non-Injury
Upper Arm Non-Injury
Lower Leg Injury
Upper Arm Injury
Ectopic Pregnancy; Known / Suspected
Bluish Skin (Cyanosis) (Paediatric)
Blisters, Foot or Hand (Paediatric)
Burns (Paediatric)
Bruises
Depression / Mood Disorders
Sore Throat / Hoarseness, Pregnant
Breast Symptoms - Female
Trauma - Toe (Paediatric)
Wrist Injury
Seizure
Hiccups
Chest Injury
Ankle Injury
Dehydration
Hypertension; Known / Suspected
Disability: Third Party Triage
Trauma - Ear (Paediatric)
Sleep Disorders

Mouth / Lip / Teeth Injury
Trauma - Mouth (Paediatric)
Heartburn, Pregnant
Suicidal and/or Homicidal Behaviour
Swallowing Difficulty
Swallowing, Difficulty (Paediatric)
Trauma - Nose (Paediatric)
Bronchiolitis: Follow-Up Call (Paediatric)
Newborn Rashes & Birthmarks (Paediatric)
Thigh Injury
Limp (Paediatric)
Trauma - Finger (Paediatric)
Seizure - without Fever (Paediatric)
Vaginal Bleeding - Menopausal, no HRT
Sinus Pain and Congestion (Paediatric)
Vomiting of Blood (Paediatric)
Implanon; Symptoms / Information
Urination - All Other Symptoms (Paediatric)
Hip Injury
Back Pain (Paediatric)
Nose, Foreign Body (Paediatric)
No Guideline Available (Paediatric)
Allergies / Hay Fever Symptoms
Chickenpox: Known / Suspected Exposure
Withdrawal Symptoms
Rash, Purple Spots or Dots (Paediatric)
Suture Questions
Acute Alcohol Intoxication
Abdominal Injury
Arm Joint, Swelling of (Paediatric)
Arm Pain (Paediatric)
Trauma - Tooth (Paediatric)
Bee Sting (Paediatric)
Bottle-Feeding Questions (Paediatric)
Uterine Prolapse; Diagnosed/Info
Vaginal Bleeding, on HRT
Athlete's Foot; Known / Suspected

Bites and Stings-Marine Life
Urinary Incontinence
Breastfeeding Questions (Paediatric)
Hypertension; Diagnosed, Pregnant
Disability: Third Party Triage Paediatric
Scarlet Fever (Paediatric)
Finger / Fingernail Non-Injury
Pelvic Pain / Dyspareunia
Forearm Non-Injury
Hand Injury
Hand/Foot/Mouth Disease; Known/Suspected
Night-time Urination
Newborn Reflexes & Behaviour (Paediatric)
Fainting (Paediatric)
Hoarseness (Paediatric)
Seen Doctor/Health Care Provider [Paediatric]
Wrist Non-Injury
Immunisation Reactions H1N1
Near Drowning [Paediatric]
Itching, Localised (Paediatric)
Muscle Ache / Pain
Jaundice, Children/Teenagers (Paediatric)
Leg Joint, Swelling of (Paediatric)
Lip, Swelling of (Paediatric)
Medication Question Encounters (Paediatric)
Newborn Pink/Brick dust Urine (Paediatric)
Medical Abortion: Symptoms/Info Guideline Comparison
Trauma - Eye (Paediatric)
Tick Bite (Paediatric)
Contact Lens Problems
Tear Duct, Blocked (Paediatric)
Cracked Skin (Paediatric)
Swollen Glands
Diabetes: Paediatric
Swallowed Foreign Body
Super Glue Exposure
Falls

Sunburn
Trauma - Genital: Male (Paediatric)
Stye (Paediatric)
Stress Response
Ear, Foreign Body (Paediatric)
Elbow Injury
Elbow Non-Injury
Skin / Rash, Pregnant
Eye - Allergy (Paediatric)
Signs of Labour, Pregnant
Seizure - with Fever (Paediatric)
Face Injury

APPENDIX M - SUMMARY OF CONSULTATIONS UNDERTAKEN IN RELATION TO SERVICE CAPACITY MAPPING, THE UTILIZATION OF SERVICES AND IDENTIFICATION OF GAPS IN AFTER HOURS PRIMARY CARE

Service Name		Service Type	Date Consulted
1.	Aboriginal Medical Services Alliance of the Northern Territory – AMSANT Member Operations Reference for Public Health group meeting	Peak Body	28 November 2012
2.	Alice Springs After Hours GP Clinic	Cooperative General Practice	22 February 2013
3.	Alice Springs Family Medical Centre	Private General Practice	4 March 2013
4.	Alice Springs Hospital, Department of Health	Hospital	21 February 2013
5.	Anyinginyi Health Aboriginal Corporation	Aboriginal Community Controlled Health Organisation	5 March 2013
6.	Arafura Medical Centre	Private General Practice	28 February 2013
7.	Bath Street Medical Clinic	Private General Practice	4 March 2013
8.	Casuarina Square Medical and Dental	Private General Practice	20 February 2013
9.	Cavenagh Medical Centre	Private General Practice	28 February 2013
10.	Central Australian Aboriginal Congress	Aboriginal Community Controlled Health Organisation	4 March 2013

Service Name		Service Type	Date Consulted
11.	Central Clinic	Private General Practice	5 March 2013
12.	Danila Dilba	Aboriginal Community Controlled Health Organisation	28 February 2013
13.	Remote Health, Department of Health	Northern Territory Government	9 January 2013
14.	Dr Vicki Beaumont Surgery	Private General Practice	20 February 2013
15.	Endeavour Medical Centre	Private General Practice	19 February 2013
16.	FCD Health • Palmerston GP Super Clinic; and • Charles Darwin University Medical Centre	Not for profit joint venture	20 February 2013
17.	Gorge Health	Private General Practice	15 February 2013
18.	Katherine After Hours Clinic	Private General Practice	15 February 2013
19.	Health Scope Independence Services	Health Service Provider	11 February 2013
20.	Howard Springs Health Centre	Private GP	20 February 2013
21.	Katherine Hospital, Department of Health	Hospital	26 February 2013

Service Name		Service Type	Date Consulted
22.	Katherine Isolated Children and Parents Association	NGO	26 February 2013
23.	Katherine Town Council	Local Government	26 February 2013
24.	Katherine West Health Board	Aboriginal Community Controlled Health Organisation	25 February 2013
25.	Kintore Clinic	Private General Practice	25 February 2013
26.	Larapinta Drive Medical Centre (incorporating Alice Springs Chiropractic)	Private GP and chiropractor	18 February 2013
27.	Mall Medical Centre	Private General Practice	21 February 2013
28.	Mental Health Association of Central Australia	Health Consumer Representative Group	4 March 2013
29.	Moil Medical Centre	Private General Practice	6 March 2013
30.	Nhulunbuy – Clinical and Public Health Advisory Group	Clinical and Public Health Advisory Group	19 February 2013
31.	• Northlakes Medical Centre; and • Vanderlin Drive Clinic	Private General Practice	13 March 2013
32.	Northern Territory Medicare Local	Peak Body	15 February 2013
33.	• Palmerston Medical Clinic; • Nakara Medical Centre;	Private General Practice	7 March 2013

Service Name		Service Type	Date Consulted
	and • Tiwi Medical Centre		
34.	Pharmacy Guild	Peak Body	3 December 2012
35.	Ochre Health	Not for Profit Medical Provider	6 March 2013
36.	Rapid Creek After Hours Practice	Private General Practice	11 March 2013
37.	Royal Flying Doctor Service - Alice Springs Base	Patient transport	4 March 2013
38.	Royal Flying Doctor Service - Tennant Creek GP Practice	Private General Practice	1 March 2013
39.	St John Ambulance - Katherine	Patient Transport	27 February 2013
40.	St John Ambulance - Darwin	Patient Transport	Various dates
41.	Stuart Park Surgery & After Hours Medical Practice	Private GP	5 and 6 February 2013
42.	Sunrise Health Service	Aboriginal Community Controlled Health Organisation	27 February 2013
43.	Tennant Creek Hospital, Department of Health	Hospital	13 March 2013
44.	Territory Medical Group	Private General Practice	7 March 2013
45.	Top End Medical Centre	Private General Practice	28 February 2013
46.	Wurli Wurlinjang	Aboriginal Community Controlled Health Organisation	7 March 2013

APPENDIX N - SUMMARY OF CONSULTATIONS UNDERTAKEN TO PRIORITIZE THE GAPS IN AFTER HOURS PRIMARY CARE

The Northern Territory Medicare Local established a Steering Committee to provide oversight of the Health Needs Assessment being undertaken at the same time. At the Steering Committee's first meeting on 14 December 2012, it was agreed that a Sub Committee would be formed to provide governance and direction in the priority-setting process for the After Hours Project.

The Sub-Committee's membership was drawn from existing members of the Steering Committee, together with additional members from the private sector.

Membership of this group was:

- Dr Andrew Bell - Chair, NTML Board
- Chips Mackinolty - Policy Advisor, AMSANT (was not able to attend any meetings)
- Dr Jim Thurley – Clinical Advisor, NTML
- Dr Christine Lesnikowski - GP, Mall Medical Centre
- Amalie Andropov - Managing Director, Territory Medical Group
- Veronica Snook - Director, System Performance, Department of Health
- Ruth Debuque - Practice Manager, Casuarina Square Medical and Dental Service

The Sub Committee met on the following dates:

- 18 February 2013; and
- 8 March 2013

Additional work was conducted out of session

After Hours Needs Assessment – Sub-Committee

Terms of Reference **January 2013**

Background & Context

Medicare Locals have been tasked with a range of after hours primary health care roles and responsibilities.

An initial role for Medicare Locals is to undertake a needs assessment to identify gaps in access to after hours primary health care within their catchment area. Medicare Locals will then develop and implement a plan to efficiently and effectively address priority gaps identified during this needs assessment. From 1 July 2013, Medicare Locals will administer additional funding to address identified priority gaps.

The Northern Territory Medicare Local (NTML) is responsible for the development of an NT-wide plan on after hours primary health care, for submission to the Department of Health and Ageing by 28 March 2013.

After Hours Assessment Sub-Committee

The After Hours Needs Assessment Sub-Committee ('the Sub-Committee') will be responsible for ensuring that services to be funded from 1 July 2013 provide accessible care (namely that care is appropriate, timely, available, affordable and equitable) and effective care (namely care that is continuous, coordinated, quality and safety assured, efficient and sustainable). This ensures that all decisions made on funding services under After Hours Stage 2 is consistent with the *Medicare Locals: Guidelines for After Hours Primary Care Responsibilities until 30 June 2013* and the *Medicare Local After Hours Program: Supporting Guidance: Developing a Stage Two Plan to Commence 1 July 2013.*

The Sub-Committee is a specific committee of the Needs Assessment Steering Committee ('the Steering Committee') which has oversight of the broader NT-wide Needs Assessment Project.

Roles & Functions

The roles and functions of the Sub-Committee include:

- To consider and review the findings gathered from the needs assessment that inform the After Hours Stage 2 project;
- Make recommendations to the Steering Committee and/or the NTML Board on priorities to be identified to DOHA for funding post 1 July 2013; and
- To provide leadership, advice and expertise to the recommendations prioritised in the NT-wide plan on after hours care, to ensure all stakeholders are engaged and a streamlined funding transition process occurs.

Membership

The Sub-Committee shall be appointed by the Steering Committee and will comprise at least one member of the NTML Board, and other independent members who bring expertise and knowledge about primary health care service delivery in the NT, including Aboriginal community controlled health services.

Probity & Conflict of Interest

Members have obligations to declare any actual or potential conflicts of interest (e.g. financial, professional).

Duration of Membership

Appointment of independent members to the Sub-Committee shall be up to six months, and can be extended depending on any emerging priorities not yet identified.

Privacy & Confidentiality

Members will be expected to maintain confidentiality and operate in accordance with privacy principles where the group is dealing with sensitive matters. To support a pro-active solutions focus, confidential discussions will be undertaken without fear or favour.

It is the responsibility of the Chair and the member raising/discussing an issue to identify matters of a confidential nature.

Member Roles & Responsibilities

Members are responsible for:

- Consulting and liaising with the Steering Committee;
- Providing feedback regarding meeting outcomes and decisions to the Steering Committee and/or Board.

Meeting Frequency

The Sub-Committee will meet as required. Electronic and other media will be used to convene meetings as appropriate.

Meeting Chair

The Chair and Deputy Chair of the Sub-Committee will be determined by the members of the Sub-Committee.

Quorum

A quorum will consist of a minimum of three members.

Executive Support

Executive support will be provided by NTML. Executive support responsibilities include:

- Collating and circulating meeting papers
- Writing and circulating meeting minutes
- Maintaining and circulating a list of documents tabled during meetings
- Arranging meeting venues, including teleconference arrangements
- Arranging catering/refreshments if relevant

Agendas

All members have equal rights to list items for the Agenda.

Meeting Papers

Agenda items and meeting papers will be submitted to members at least five days prior to the meeting.

Minutes

Minutes comprising main points of a topic and agreed action will be produced by the Executive Support. Confidential items are not, in general, to be minuted. Minutes will be documented and circulated to members within five working days of the meeting.

Minutes shall be kept. Minutes will be signed by the Sub-Committee Chair. Minutes hall be circulated to the full Needs Assessment Steering Committee and the Board.

Fees

Director's attendance at Sub-Committee meetings is considered to be part of regular Board duties covered by Board stipend arrangements unless otherwise specified.

Remuneration of the independent members of the Sub-Committee will be in accordance with the NTML policy *Remuneration for participation by the Community in NTML Committees.*

List of Members (as at 25 January 2013*):

- Dr Andrew Bell Chair, NTML Board
- Chips Mackinolty - Policy Advisor, AMSANT
- Dr Christine Lesnikowski GP, Mall Medical Centre
- Amalie Andropov - Managing Director, Territory Medical Group and Practice Liaison Officer, NTGPE
- Veronica Snook - Director, System Performance, Department of Health
- Ruth Debuque - Practice Manager, Casuarina Square Medical and Dental Service

*Dr Jim Thurley invited to join the Sub-Committee in February 2013.

APPENDIX O - NORTHERN TERRITORY PLAN ON AFTER HOURS PRIMARY HEALTH CARE: JUNE 2013 – JULY 2014

Priority 1	
Health need/service gap that will be addressed.	**The availability of future funding for after hours primary health care services post 1 July 2013** *Ongoing provision of existing After Hours services currently provided by General Practice (through Practice Incentive Program [PIP] Payments) are maintained with the proviso that service use data is provided to the NTML for future planning post 30 June 2014.*
Activity/ies that will be undertaken to address the issue.	*April – June 2013* *i. Develop with services a reporting/ accountability framework that will capture After Hours Service use. This will capture data such as MBS Item numbers, billing type, type of presentation, Indigenous vs. Non-Indigenous, etc.* *ii. Communicate with all General Practices eligible for After Hours PIP Payments relating to the ongoing availability of the program for 2013/14 with the additional reporting requirements to NTML* *iii. Develop registration and payment system* *iv. Develop service agreements and reporting structures* *July 2013 – June 2014* *v. New funding arrangements to commence* *vi. Review of data collected and evaluation of system implemented for 2013/14* *Twenty-five General Practices and Aboriginal Community Controlled Health Organisations currently receive some level of After Hours PIP*

	Payment. These services will register with the NTML with details being made available to the Department of Health and Ageing prior to 26 April 2013. *The Tiers and Guidelines for payment will be modelled on those currently delivered under Medicare Australia's After Hours PIP Payments.* *Developing and implementing data collection structures will enable the NTML to assess the PIP payment system throughout 2013/14 with a view to resourcing effective use of PIP payments in the following year (2014/15). Following this assessment, a re-distribution of funding from services that are not delivering value may occur. This may include a review of the program guidelines, Tier structure and/or other eligibility and reporting requirements.* *The NTML will develop reporting tools to be used by funding recipients (e.g. exploring the use of electronic reporting systems or other templates)*
Stakeholders the ML will work with to undertake the activity.	• *General Practices currently in receipt of this payment* • *Aboriginal Community Controlled Health Organisations currently in receipt of this payment* *In developing the plan, the following stakeholders were consulted: GPs, General Practices, NT Department of Health, Consumer Representative Groups* *The NTML After Hours Project Sub-Committee consisted of: 2 x Practice Managers, 1 x Department of Health Representative, 1 x GP, 1 x AMSANT Representative, 1 x NTML Board Member, 1 x NTML Clinical Services Advisor*
Fund Priority that the activity/ies relates to.	Fund Priority 1 – Promote, facilitate and improved access to appropriate primary health care services.

Level of funding allocated for the activity/ies.	***$270,000*** ***Note - PIP allocation for 2011 was $244,166* *Allocation to be increased due to variations in payment (payment of PIP dependent on practices Standardized Whole Patient Equivalent figure which can vary between quarters). Also allows for GST component, which Medicare Locals will now have to incorporate within this payment.*
Objective of the activity (Note: objective should be SMART).	Provide ongoing funding to support General Practices currently providing after hours services, so that these services are continued following the change in funding arrangements post-1 July 2013. During 2013/14 after hours service access and usage data will be gathered to inform future planning and funding arrangements.
How the objective will be measured.	<u>Overarching Medicare Local After Hours Program Key Reporting Areas:</u> • Details of service providers funded for continuity of after hours services; service providers funded for additional/new after hours services, funding requests from service providers that were not successful; and service providers that will not be supported from 1 July 2013 • Number of ML supported services in the sociable and unsociable hours – distinction between service enhancement, new service or service maintenance ' • Comparison between the availability of services <u>now</u> and when their first needs assessment was completed • Any specific support for GPs and other health professionals involved in after hours services. • Number and location of education campaigns/programs, i.e. training and information, for health professionals. • Number and location of education campaigns/programs, i.e. training and information, for consumers. • If available, local evaluation results, including consumer feedback on the accessibility and quality of the service. <u>Activity Specific</u> Additional evaluation of the objective may include: • Amount of funding provided • Levels of funding provided (e.g. across the three tiers) across the NT

	• Comparison of PIP recipients between 2011/12 and 2013/14 • Services receiving payments to enter into service agreements with the NTML, allowing for data collection to be included in KPIs. The NTML will work in collaboration with services to develop data sets and reporting frameworks. Proposed KPIs relating to service usage could include: o Number of patients seen o Demographic data for after hours service users o Items billed in the After Hours period

Priority 2	
Health need/service gap that will be addressed.	**The availability of future funding for after hours primary health care services post 1 July 2013** *Expand availability of the After Hours PIP Payments for additional providers of after hours primary health care, with a particular focus on services in remote and regional areas who meet the eligibility criteria*
Activity/ies that will be undertaken to address the issue.	*June – December 2013* *i. Develop modified eligibility criteria for remote areas outside regional towns* *ii. Develop system to verify eligibility criteria requirements* *iii. Identify and promote the availability of After Hours PIP Payments to eligible practices in remote and regional areas* *iv. Develop registration and payment system* *v. Develop service agreements and reporting structures* *January – July 2014*

	vi. New funding arrangements to commence *vii. Review of data collected and evaluation of system implemented for 2013/14* *The Tiers and Guidelines for payment will be modelled on those currently delivered under Medicare Australia's After Hours PIP Payments.* *Developing and implementing data collection structures will enable the NTML to assess the PIP payment system throughout 2013/14 with a view to resourcing effective use of PIP payments in the following year (2014/15). Following this assessment, a re-distribution of funding from services that are not delivering value may occur. This may include a review of the program guidelines, Tier structure and/or other eligibility and reporting requirements.* *The NTML will develop reporting tools to be used by funding recipients (e.g. exploring the use of electronic reporting systems or other templates)*
Stakeholders the ML will work with to undertake the activity.	• *Accredited services who have a SWPE established – includes General Practice and Aboriginal Community Controlled Health Organisations* *In developing the plan, the following stakeholders were consulted: GPs, General Practices, NT Department of Health, Consumer Representative Groups* *The NTML After Hours Project Sub-Committee consisted of: 2 x Practice Managers, 1 x Department of Health Representative, 1 x GP, 1 x AMSANT Representative, 1 x NTML Board Member, 1 x NTML Clinical Services Advisor*
Fund Priority that the activity/ies relates to.	Fund Priority 1 – Promote, facilitate and improved access to appropriate primary health care services.

Level of funding allocated for the activity/ies.	***$125,000***
Objective of the activity (Note: objective should be SMART).	To provide after hours PIP payments to eligible services (e.g. accredited services who have a SWPE established) not currently accessing these payments to achieve equitable levels of funding for after hours activities across the NT. During 2013/14 after hours service access and usage data will be gathered to inform future planning and funding arrangements.
How the objective will be measured.	<u>Overarching Medicare Local After Hours Program Key Reporting Areas:</u> • Details of service providers funded for continuity of after hours services; service providers funded for additional/new after hours services, funding requests from service providers that were not successful; and service providers that will not be supported from 1 July 2013 • Number of ML supported services in the sociable and unsociable hours – distinction between service enhancement, new service or service maintenance ' • Comparison between the availability of services <u>now</u> and when their first needs assessment was completed • Any specific support for GPs and other health professionals involved in after hours services. • Number and location of education campaigns/programs, i.e. training and information, for health professionals. • Number and location of education campaigns/programs, i.e. training and information, for consumers. • If available, local evaluation results, including consumer feedback on the accessibility and quality of the service. <u>Activity Specific:</u> Additional evaluation of the objective may include: • Amount of funding provided • Levels of funding provided (e.g. across the three tiers) across the NT • Services receiving payments to enter into service agreements with the NTML, allowing for data collection to be included in KPIs. The NTML will work in collaboration with services to develop data sets and reporting frameworks. Proposed KPIs relating to service usage could include:

	○ Number of patients seen ○ Demographic data for after hours service users ○ Items billed in the After Hours period

Priority 3 (A, B and C)	
Health need/service gap that will be addressed.	**A. Likely ending of the current dedicated after hours service in Alice Springs and the need to develop a service which is accessible, affordable and best meets the needs of the local community** **B. Limited availability of After Hours Services in Katherine** **C. Limited availability of After Hours Services in Tennant Creek** *Target grants to develop and implement models of After Hours Primary Health Care service delivery in the regional centres of Alice Springs, Katherine and Tennant Creek. This includes:* • *Alice Springs which has expressed an interest in redefining an existing After Hours model which will cease operating under its current governance arrangement 30 June 2013* • *Katherine which has limited After Hours care (Tuesday and Thursday 7 - 9 pm; and Sunday 10 am – 12 pm) based on service collaboration and identification of capacity, and appropriateness as identified by the PHC partners* • *Tennant Creek which currently provides After Hours only through the Hospital Emergency Department*
Activity/ies that will be undertaken to address the issue.	*Set amount of funding to be made available in Alice Springs, Katherine and Tennant Creek to develop and implement a proposal for the delivery or enhancement of After Hours Primary Health Care services in their community for 2013/14.* *June – October 2013*

	I. *Establish funding service criteria* II. *Allocation of funds for After Hours delivery that demonstrates collaborative planning with other providers, utilization of existing capacity and resources, appropriateness to the known needs of the community* III. *Funding areas to be considered include telehealth and use of emerging technologies, transportation issues, workforce sustainability, nurse practitioner model, interface with Hospital Emergency Department* IV. *Review and approve service models* V. *Develop service agreements and reporting structures* *October 2013 – June 2014* VI. *New funding arrangements to commence* *The NTML will develop reporting tools to be used by funding recipients (e.g. exploring the use of electronic reporting systems or other templates)*
Stakeholders the ML will work with to undertake the activity.	• *Develop local working groups consisting of local providers (including General Practice, Aboriginal Community Controlled Health Organisations, Ambulance Services and hospitals) and community and consumer representatives* • *Clinical and Public Health Advisory Group (if existing)* • *Other existing Primary Health Care network* • *Alternate facilitation by NTML with AMSANT if no existing group/network* *In developing the plan, the following stakeholders were consulted: GPs, General Practices, NT Department of Health, Consumer Representative Groups* *The NTML After Hours Project Sub-Committee consisted of: 2 x Practice Managers, 1 x Department of Health Representative, 1 x GP, 1 x*

	AMSANT Representative, 1 x NTML Board Member, 1 x NTML Clinical Services Advisor
Fund Priority that the activity/ies relates to.	Fund Priority 1 – Promote, facilitate and improved access to appropriate primary health care services.
Level of funding allocated for the activity/ies.	***$300,000*** *To be comprised of the following allocations:* *A. Alice Springs - $150,000* *B. Katherine - $75,000* *C. Tennant Creek - $75,000*
Objective of the activity (Note: objective should be SMART).	To establish local models to develop and deliver appropriate after hours services in the relevant region, through a collaborative process that identifies shared resources, relevance to community needs and the capacity of workforce. Local models to commence by October 2013.
How the objective will be measured.	<u>Overarching Medicare Local After Hours Program Key Reporting Areas:</u> • Details of service providers funded for continuity of after hours services; service providers funded for additional/new after hours services, funding requests from service providers that were not successful; and service providers that will not be supported from 1 July 2013 • Number of ML supported services in the sociable and unsociable hours – distinction between service enhancement, new service or service maintenance ' • Comparison between the availability of services <u>now</u> and when their first needs assessment was completed • Any specific support for GPs and other health professionals involved in after hours services. • Number and location of education campaigns/programs, i.e. training and information, for health professionals.

	• Number and location of education campaigns/programs, i.e. training and information, for consumers.
	• If available, local evaluation results, including consumer feedback on the accessibility and quality of the service.
	
	<u>Activity Specific:</u>
	
	Additional evaluation of the objective may include:
	
	• Amount of funding provided and location of service
	• Details of the new services, including governance structures
	• Evaluation from the community and other providers on any changes in levels of after hours services being provided (e.g. changed waiting times)
	• Services receiving payments to enter into service agreements with the NTML, allowing for data collection to be included in KPIs. The NTML will work in collaboration with services to develop data sets and reporting frameworks. Proposed KPIs relating to service usage could include:
	  ○ Number of patients seen
	  ○ Demographic data for after hours service users
	  ○ Items billed in the After Hours period

Priority 4	
Health need/service gap that will be addressed.	**Lack of awareness of available after hours services and their most appropriate use, with different requirements in urban and regional/remote settings** *There is high turnover of residents, including the health workforce, in the Northern Territory, and an identified need to ensure community members are aware of available after hours services in their communities.*

Activity/ies that will be undertaken to address the issue.	*Part 1 – In consultation with stakeholders, development of a central directory of primary health care services – with a particular focus on after hours services and their fees etc. (e.g. directory, web-site, smart phone applications).* *i. Audit of existing information and resources* *ii. Information checking* *iii. Development of system for ongoing information checking* *iv. Design and development of resources, including directory* *v. Distribution and publicizing of directory* *vi. Publicizing after hours GP helpline on NTML web-site and other avenues* *vii. Development of specific After Hours Section on NTML web-site, linked to Facebook and Twitter accounts* *Part 2 – In consultation with stakeholders, develop and deliver a communication campaign relating to the most appropriate use of After Hours Primary Health Care Services e.g. to reduce (where appropriate) acute presentations to GP services and to reduce (where appropriate) GP-type attendances to hospital Emergency Departments. This process will include an audit of existing health awareness programs relating to the use of hospitals and/or primary health care services. Consultation will occur with other providers and consumers/consumer groups to ensure effective and appropriate messaging.* *The NTML will develop reporting tools to be used by funding recipients (e.g. exploring the use of electronic reporting systems or other templates)*
Stakeholders the ML will work with to undertake the activity.	• *Internal NTML stakeholders – Communications Officer, Workforce, Member Services* • *General Practice* • *Aboriginal Community Controlled Health Organisations* • *Department of Health* • *NGOs that deliver health promotion programs and messages* • *The Community* • *Consumers and consumer representative groups*

	In developing the plan, the following stakeholders were consulted: GPs, General Practices, NT Department of Health, Consumer Representative Groups *The NTML After Hours Project Sub-Committee consisted of: 2 x Practice Managers, 1 x Department of Health Representative, 1 x GP, 1 x AMSANT Representative, 1 x NTML Board Member, 1 x NTML Clinical Services Advisor*
Fund Priority that the activity/ies relates to.	Fund Priority 1 – Promote, facilitate and improved access to appropriate primary health care services.
Level of funding allocated for the activity/ies.	***Total: $62,884*** ***Part 1 - $15,000*** *Staff wages for resource development to be completed using internal NTML resources plus additional for development of any social media material* ***Part 2 – $47,884*** *Media space purchasing - $20,000* *Engagement of external Contractor for three month period estimated $27,884*
Objective of the activity (Note: objective should be SMART).	Part 1 – By June 2014, there will be a self-reported increase in consumer and provider knowledge of available after hours services and how to access them. Part 2 – By June 2014, there will be a self-reported increase in consumer knowledge of the most appropriate types of presentations to after

	hours GP Services and to hospital Emergency Departments.
How the objective will be measured.	<u>Overarching Medicare Local After Hours Program Key Reporting Areas:</u> • Details of service providers funded for continuity of after hours services; service providers funded for additional/new after hours services, funding requests from service providers that were not successful; and service providers that will not be supported from 1 July 2013 • Number of ML supported services in the sociable and unsociable hours – distinction between service enhancement, new service or service maintenance • Comparison between the availability of services <u>now</u> and when their first needs assessment was completed • Any specific support for GPs and other health professionals involved in after hours services. • Number and location of education campaigns/programs, i.e. training and information, for health professionals. • Number and location of education campaigns/programs, i.e. training and information, for consumers. • If available, local evaluation results, including consumer feedback on the accessibility and quality of the service. <u>Activity Specific:</u> Additional evaluation of the objective may include: • Number of hits on NTML website section on After Hours • Type and amount of any resources developed • Location, organisation and type of resources distributed • Consumer evaluation/awareness survey pre and post campaign • Provider evaluation/awareness survey pre and post campaign • Monitoring data received from Health Direct Australia to ascertain any impact of increased publicity campaign through the NTML • Monitoring any changes in public hospital Emergency Department presentations and after hours GP attendances as evidence of

	change in consumer understanding.

Priority 5	
Health need/service gap that will be addressed.	**Security for remote health centre staff attending after hours call-outs (focus on East Arnhem)** *Increasing the after hours on-call capacity of the Ngalkanbuy Clinic at Galinwinku on Elcho Island.* *This activity is a time limited trial. Learning's from this project will inform future after hours service delivery in similar communities.*
Activity/ies that will be undertaken to address the issue.	*Contract with Miwatj Health Aboriginal Corporation to employ local Indigenous person/persons to work on the roster to provide additional on-call support, including security and liaison with the local community where appropriate. This service will also provide health literacy training and education to the community regarding the "appropriate" use of after hours on-call services.* *Note – this service was identified during Stage 1 of the After Hours Program. Activity funded until 30 June 2013 under Stage 1 funding.* *The NTML will develop reporting tools to be used by funding recipients (e.g. exploring the use of electronic reporting systems or other templates)*
Stakeholders the ML will work with to undertake the activity.	• *Miwatj Health Aboriginal Corporation* *In developing the plan, the following stakeholders were consulted: GPs, General Practices, NT Department of Health, Consumer Representative*

	Groups *The NTML After Hours Project Sub-Committee consisted of: 2 x Practice Managers, 1 x Department of Health Representative, 1 x GP, 1 x AMSANT Representative, 1 x NTML Board Member, 1 x NTML Clinical Services Advisor*
Fund Priority that the activity/ies relates to.	Fund Priority 1 – Promote, facilitate and improved access to appropriate primary health care services.
Level of funding allocated for the activity/ies.	***$65,000*** *Annual cost of service $94,596 – DoHA has advised unspent funding from 2012/13 can be rolled over into 2013/14. Funding likely to be required to continue this activity for 2013/14 from Stage 2 funding ($1.2 M) to be $65,000 based on assumption of funding rollover of $30,000*
Objective of the activity (Note: objective should be SMART).	To maintain after hours on-call services provided by the staff of the Ngalkanbuy Health Centre. To ensure the safety of the Ngalkanbuy Health Centre staff and community members, when attending after hours call-outs.
How the objective will be measured.	<u>Overarching Medicare Local After Hours Program Key Reporting Areas:</u> • Details of service providers funded for continuity of after hours services; service providers funded for additional/new after hours services, funding requests from service providers that were not successful; and service providers that will not be supported from 1 July 2013 • Number of ML supported services in the sociable and unsociable hours – distinction between service enhancement, new service or service maintenance ' • Comparison between the availability of services <u>now</u> and when their first needs assessment was completed • Any specific support for GPs and other health professionals involved in after hours services. • Number and location of education campaigns/programs, i.e. training and information, for health professionals. • Number and location of education campaigns/programs, i.e. training and information, for consumers.

	• If available, local evaluation results, including consumer feedback on the accessibility and quality of the service. <u>Activity Specific:</u> Additional evaluation of the objective may include: • Number, time and type of after hours calls attended • Number, age, gender and Indigenous status of patients seeking assistance after hours • Nature of the response to after hours calls, including use of driver/community worker for each attendance • Community evaluation of the service • Provider evaluation of the service

Priority 6	
Health need/service gap that will be addressed.	**Limited after hours medical services available in the Laynhapuy Homelands (focus on East Arnhem)** *Improving the after hours on-call capacity to the Laynhapuy Homelands in East Arnhem.* *This activity is a time limited trial. Learning's from this project will inform future after hours service delivery in similar communities.*
Activity/ies that will be undertaken to address the issue.	*Contract with Layna Health (through the Laynhapuy Homeland Aboriginal Corporation) to employ local Indigenous people in Community Health Worker roles (at Birany Birany and Dhalinybuy Outstations) to provide after hours medical triage to members of the community. These workers would also act as liaison between the patient, their family and other health care services, including Remote Medical Practitioners. This service will also provide health literacy training and education to the community regarding the "appropriate" use of after hours on-call services.*

	Note – this service was identified during Stage 1 of the After Hours Program. Activity funded until 30 June 2013 under Stage 1 funding. *The NTML will develop reporting tools to be used by funding recipients (e.g. exploring the use of electronic reporting systems or other templates)*
Stakeholders the ML will work with to undertake the activity.	• *Laynhapuy Homelands Aboriginal Corporation* *In developing the plan, the following stakeholders were consulted: GPs, General Practices, NT Department of Health, Consumer Representative Groups* *The NTML After Hours Project Sub-Committee consisted of: 2 x Practice Managers, 1 x Department of Health Representative, 1 x GP, 1 x AMSANT Representative, 1 x NTML Board Member, 1 x NTML Clinical Services Advisor*
Fund Priority that the activity/ies relates to.	Fund Priority 1 – Promote, facilitate and improved access to appropriate primary health care services.
Level of funding allocated for the activity/ies.	***$97,000*** *Annual cost of service $153,000 – DoHA has advised unspent funding from 2012/13 can be rolled over into 2013/14. Funding likely to be required to continue this activity for 2013/14 from Stage 2 funding ($1.2 M) to be $97,000 based on assumption of funding rollover of $56,000 for Stage 1*
Objective of the activity (Note: objective should be SMART).	To provide after hours on-call services to residents in the Birany Birany and Dhalinybuy Outstations, with the aim of reducing unnecessary medical emergency transport and medical evacuations after hours.

How the objective will be measured.	<u>Overarching Medicare Local After Hours Program Key Reporting Areas:</u> • Details of service providers funded for continuity of after hours services; service providers funded for additional/new after hours services, funding requests from service providers that were not successful; and service providers that will not be supported from 1 July 2013 • Number of ML supported services in the sociable and unsociable hours – distinction between service enhancement, new service or service maintenance ' • Comparison between the availability of services <u>now</u> and when their first needs assessment was completed • Any specific support for GPs and other health professionals involved in after hours services. • Number and location of education campaigns/programs, i.e. training and information, for health professionals. • Number and location of education campaigns/programs, i.e. training and information, for consumers. • If available, local evaluation results, including consumer feedback on the accessibility and quality of the service. <u>Activity Specific:</u> Additional evaluation of the objective will include: • Number, time and type of after hours services provided • Number, age, gender, location and Indigenous status of patients seeking assistance after hours • Responses to after hours requests for service • Number of evacuations