Position Paper: The case for a needs-based approach to NSW Urgent Care Clinic allocations

New South Wales Primary Health Network

September 2022

Acknowledgements

This report is written on behalf of all New South Wales (NSW) Primary Health Networks (PHNs):

- Central and Eastern Sydney
- Hunter New England & Central Coast
- Murrumbidgee
- Nepean Blue Mountains
- North Coast
- Northern Sydney
- South Eastern New South Wales
- South Western Sydney
- Western New South Wales
- Western Sydney

We acknowledge the traditional custodians of the lands across our region and pay respect to the Elders past, present and emerging. We acknowledge Aboriginal and Torres Strait Islander peoples as Australia's First Peoples and honour the rich diversity of the world's oldest living culture.

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Introduction

Australia's health system performs well globally, but it has been tested like never before by the COVID-19 pandemic, with existing pain points also exacerbated by workforce shortages and a population with increased health needs and shifting expectations. With national health expenditure growing at a faster rate than Gross Domestic Product (at 7% on average per annum) and increased operational pressure on frontline health services attributed to population changes in the next decade, incremental quality improvement and adjustment to the current service delivery paradigm in primary care is unlikely to achieve the transformational change required to shift health demand and capacity imbalances (AIHW, 2019).

Currently, more than one in three presentations to hospital emergency departments (EDs) are for lower urgency care, some of which may be managed more appropriately by General Practitioners (GP) and primary care in the community (AIHW, 2022). This trend is even greater in rural and remote communities, and for specific population cohorts including Aboriginal and Torres Strait islander people and younger people (AIHW, 2022).

Health system usage and other data demonstrate increasing demand and service needs across New South Wales. The data indicates that the ageing population is creating strong demand for primary care while younger generations are utilising low urgency care in hospital EDs at rates often above the national average.

However, the solution to diverting inappropriate less urgent hospital presentations is not straightforward – the capacity of the primary care sector and GPs to absorb this demand is limited. The use of **GP services across Australia increased 15.1% from 2013 to 2021** and numerous reports have identified the GP workforce pipeline requires significant intervention and support to meet forecasted population health needs (HNC, 2021). As such, despite Commonwealth and state government efforts to increase capacity of primary care services, in many communities there remains a reliance on hospital care for urgent low acuity care, particularly afterhours.

The Albanese Government made an election commitment of $135 million to trial 50 urgent care clinics across Australia over 4 years and is now working through the Department of Health and Ageing to implement this commitment. Labor's Medicare Urgent Care Clinics will be based in existing GP clinics and Community Health Centres and provide bulk billed services delivered by doctors and nurses, with no appointment necessary. Each Medicare Urgent Care Clinic will be different, responding to the needs of the local community, with the size of clinics depending on local needs. Further to this federal government commitment, the New South Wales and Victorian governments have announced that each state will establish 25 urgent care services in partnership with General Practitioners (GPs) bringing the total number of services across both states to 50 (Perrottet & Andrews, 2022). We are pleased to see that the "locations of future urgent care services in New South Wales will be delivered where there is greatest need, based on the demands experienced by hospital EDs, including where services can be scaled up quickly" (Perrottet & Andrews, 2022) – as such, **this Position Paper seeks to equip the New South Wales and Australian governments with the evidence base to inform appropriate and impactful urgent care centre investment in NSW.**

The New South Wales and ACT PHN network commend the Australian Government commitment of $135 million to establish 50 urgent care clinics across Australia, and the recent New South Wales government commitment to establish 25 urgent care services across New South Wales.

We applaud this focus on diverting lower acuity patients to primary care outside of the Emergency Department setting. However, we advocate for evidence and needs based Urgent Care Clinic placement in New South Wales to ensure the greatest impact on improved efficiency and sustainability of the health system that enables patients to receive care in the most appropriate setting in a timely manner. We also advocate for a collaborative state and federal approach, to ensure services are appropriately integrated and implementation does not further deplete capacity in primary care system.

To fundamentally change current patterns of demand and improve long term population health outcomes, the opportunity to invest in data driven, contemporary models of care with longer term sustainability, are critical. As such, this Position Paper intends to inform the design and strategic placement of UCC placement across New South Wales that will ultimately ensure government investment achieves intended outcomes – a reduction in avoidable low acuity Emergency Department presentations. Specifically, this report includes recommendations on higher priority geographical locations for UCC placement in New South Wales, identified through targeted data analysis of key indicators of population need at the level of each Primary Health Network in New South Wales.

Summary of findings

All Primary Health Networks (PHNs) across New South Wales have collaborated to form this Position Paper, aimed at providing the Australian and New South Wales governments with:

1. key indicators to guide prioritisation of the most appropriate, needs-based UCC placement throughout New South Wales,
2. recommendations to guide appropriate positioning and implementation of UCC.

One of the goals of PHNs is to support access to primary health care, including access to appropriate afterhours services. As such, the New South Wales PHNs recommend that this evidence-based Position Paper is utilised to guide planning of UCC investments. UCC placement should be prioritised based on where population health needs and service gaps align with the key objectives of UCCs - to reduce low urgency ED presentations through appropriate patient diversion to effective primary care service delivery models.

Throughout a rigorous and evidence-based prioritisation process, we recommend UCCs be positioned in New South Wales with prioritisation in the following PHN areas, ranked from highest to lowest need (see Table 1). The rationale for this prioritisation is provided within this report and summarised in Table 4, page 27.

Table 1: New South Wales PHN ranking priority for UCC placement

Ranking Priority of PHN UCC placement
1. Western New South Wales
2. South Western Sydney, Hunter New England & Central Coast, Murrumbidgee
3. North Coast
4. South Eastern New South Wales
5. Central and Eastern Sydney
6. Western Sydney
7. Nepean Blue Mountains
8. Northern Sydney

The geographical boundaries of some New South Wales PHNs are large, with each PHN consisting of different communities with different levels of health and service needs. As such, we have further identified priority areas of need, by SA3 level in Appendix 1.

Rationale for a needs-based approach

Lower urgency ED presentations indicate primary care access challenges

General practice is critical to a well-functioning health system, however access to a GP and appropriate primary care has deteriorated with recent COVID-19 disruption and workforce attraction and retention challenges. As evidenced by the *PHN Program Performance and Quality Framework*, lower urgency ED presentations is one indicator of primary care access (Figure 1).

Figure 1: Definition of lower urgency care and what this measure indicates (ref: AIHW, 2022)

Consequently, we recommend the following indicators are utilised to prioritise UCC placement:

- ***Volume and growth of low urgency ED presentations (2016-2019).***
- ***Proportion and growth of low urgency ED presentations per 1,000 population (2016-2019).***
- ***Medicare subsidised GP attendances per 100 population and growth (2016-2021).***

Lower urgency ED presentations vary across age groups

Around 1 in 3 ED presentations (35%) were classified as lower urgency in 2018–19, equating to 117.4 presentations per 1,000 people in Australia. This rate has remained relatively stable since 2015−16 (118.4 per 1,000 people). However, younger age groups (0-24 years) made up a significant proportion of these presentations with children under 15 representing 29% of all lower urgency ED presentations, and also as a proportion of the total population this age group had the highest presentation rate (181 per 1,000 people). In contrast, people aged 65 and over accounted for only 11% of lower urgency ED presentations (80 per 1,000 people).

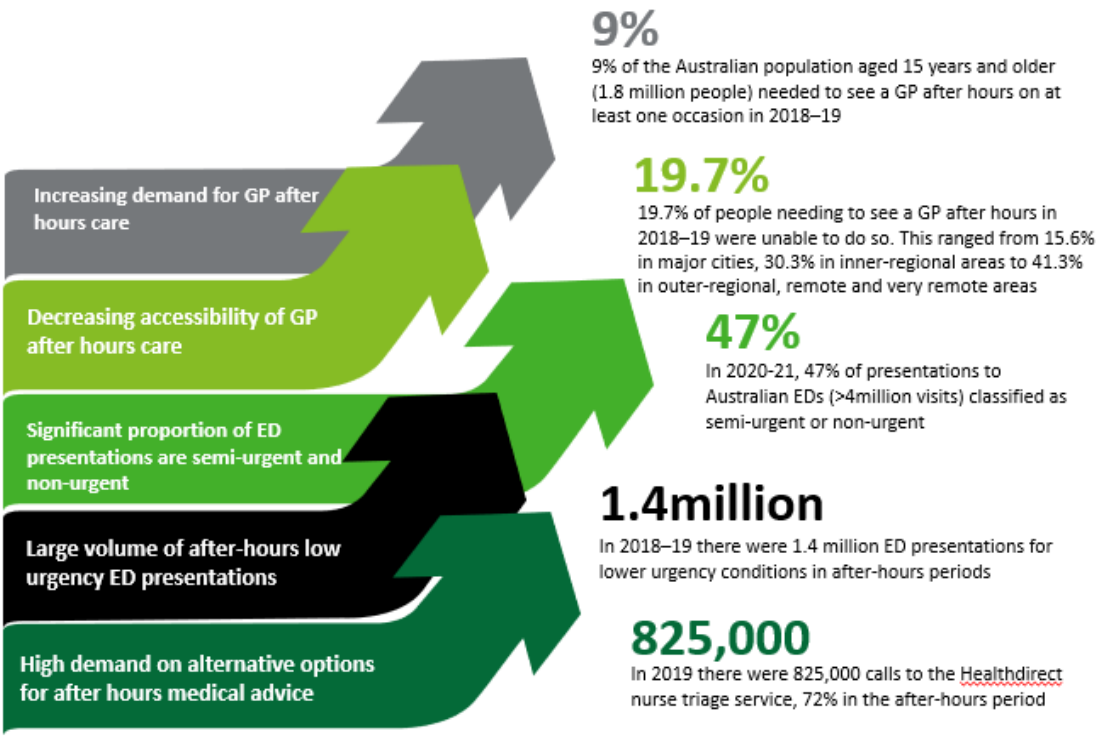
Consequently, we recommend the following indicators are utilised to prioritise UCC placement:

- ***Size of the local population cohort by age brackets.***
- ***Population growth trend by age brackets (2016-2020).***

Half of all lower urgency ED presentations are afterhours, and are variable across age groups

In 2018-19, nationally 47% of all lower urgency ED presentations occurred afterhours, when GP services are typically closed, but varied considerably across PHN areas. Of the 31 Australian PHNs, only 3 PHNs had a higher proportion of afterhours presentations than in-hours – all of which were in New South Wales, including Western Sydney (53%), Northern Sydney (52%) and South Western Sydney (52%). Further, people aged under 65 years are more likely to present to ED afterhours (48% of presentations for this age group) than people aged 65 and over (39% of presentations for this age group) (AIHW, 2019).

Figure 2: Increasing demand for afterhours lower urgency medical advice and care across Australia.



Source: Australian Bureau of Statistics, 2019-2021 and Healthdirect Aus 2019

Consequently, we recommend the following indicators are utilised to prioritise UCC placement:

- ***Afterhours GP attendances per 100 population.***

Lower urgency ED presentations vary by geographical area

People living in regional PHN areas continue to have a higher rate of lower urgency ED presentations (164 presentations per 1,000 people) than their metropolitan counterparts (90 per 1,000 people) (AIHW, 2019). In 2018−19, use of EDs for lower urgency care varies across Australia—ranging from 53 presentations per 1,000 people in Darling Downs and West Moreton Primary Health Network (PHN) area (Qld), to 333 per 1,000 people in Western New South Wales PHN area. Between 2015−16 and 2018−19, Western New South Wales PHN area consistently had the highest rate for low urgency presentations. This can be partly attributed to metropolitan areas providing a more sustainable market for GP practice afterhour services either directly or through the use of deputising services (where the scale and density of the population renders this model more feasible, safe and profitable).

The level of MBS-supported afterhours GP service utilisation varies across Australia.

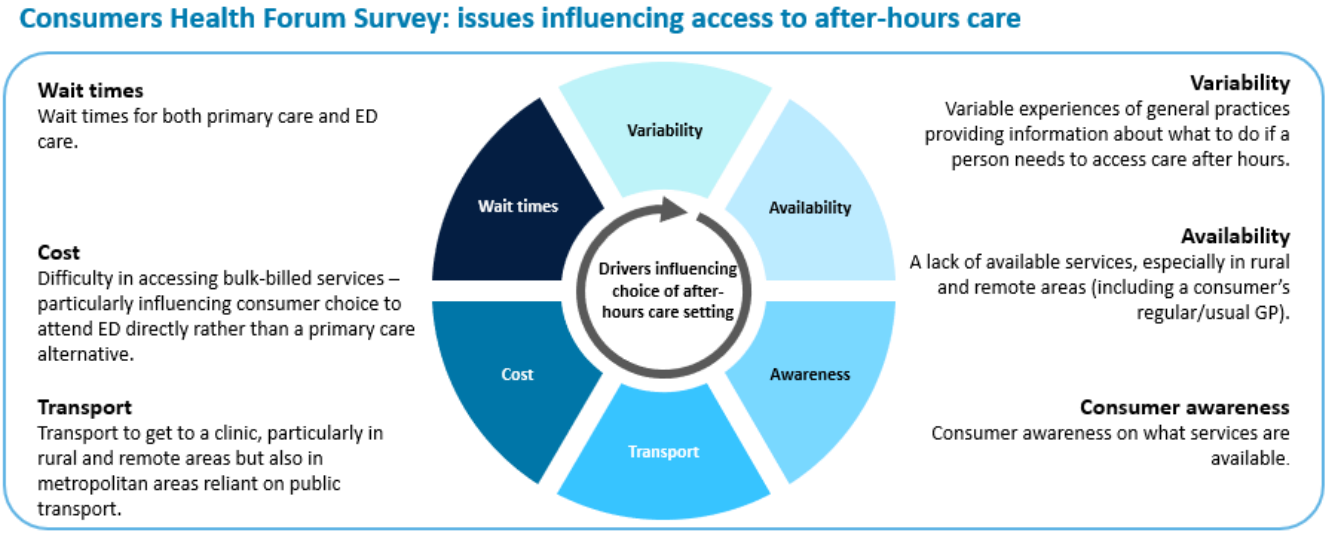
Rates of MBS supported GP afterhours services are generally higher in PHNs based in major cities (60.5 per 100 people) compared with other PHNs (26.9 per 100 people) (AIHW, 2019). The PHNs with the lowest level of these services, particularly those supporting inner- and outer-regional populations, have experienced increases since 2013–14 but remain at rates significantly below metropolitan-based PHNs.

The 2018-19 ABS Patient Experience Survey identified 21% of respondents reported going to an ED because the **GP was not available when required**, with less than 1% indicating lower cost as a decision driver. Further, 16.8% of respondents aged 15 and over who visited an ED (461,500 people) thought their care could have been provided by a GP for their most recent visit to the ED.

Specific population characteristics and local health system performance is a precursor to ED attendance for low urgency care

A survey by the ***Consumers Health Forum of Australia (2020)*** identified six key issues influencing access to afterhours care and subsequent inappropriate presentation to an ED.

Figure 3: Issues influencing access to afterhours care



Consequently, we recommend the following indicators are utilised to prioritise UCC placement:

- ***Local health service performance (Patient Off Stretcher time).***
- ***Local health service performance (National Emergency Access Target).***
- ***Socio-economic Disadvantage (Index of Relative Socio-economic Disadvantage (IRSD))***

ED usage is driven by individual self-assessment and perceptions of where a health need will be best met. Therefore, it is reasonable to infer that demand for low urgency care from young people and Aboriginal and Torres Strait Islander people particularly in areas of high social disadvantage, may be driven by difficulties accessing a GP and the high acceptability of the same day, no fee, no appointment, all-inclusive model of care provided at ED (HNC, 2019).

Consequently, we recommend the following indicators are utilised to prioritise UCC placement:

- ***Comparison of rate of low urgency ED presentations by Aboriginal and Torres Strait Islander. population, with proportion of Aboriginal and Torres Strait Islander total population within each PHN.***

Potentially preventable hospitalisations as an indicator of primary care effectiveness

Potentially preventable hospitalisations (PPH) are hospital admissions that potentially could have been prevented by timely and appropriate preventative health interventions and early disease management in primary care and community-based care settings. There are 22 conditions for which hospitalisation is considered potentially preventable, across 3 broad categories: chronic, acute and vaccine-preventable conditions. The **rate of PPH in a local area may reflect access to primary health care,** as well as sociodemographic factors and health behaviours (AIHW, 2022).

While the New South Wales PPH rate (2,483 per 100,000 people) is lower than the national rate (2,793 per 100,000 people), some specific New South Wales PHNs ranked considerably higher (AIHW, 2019).

Overall, National and New South Wales state level PHN data of PPH for 2017-18 demonstrate similar top presenting clinical diagnosis (see Figure 4). The top three diagnoses for all areas are Chronic Obstructive Pulmonary Disease, Urinary tract infections, and Dental conditions (AIHW, 2019).

Figure 4: National and New South Wales specific top Potentially Preventable Hospitalisation clinical diagnoses

National PPH clinical diagnoses

1. Dental conditions
2. Urinary tract infections, including pyelonephritis
3. Chronic Obstructive Pulmonary Disease
4. Cellulitis
5. Iron deficiency anaemia
6. Pneumonia and influenza (vaccine-preventable)
7. Congestive cardiac failure
8. Ear, nose and throat infections
9. Diabetes complications
10. Convulsions and epilepsy

NSW PPH clinical diagnoses

1. Chronic Obstructive Pulmonary Disease
2. Dental conditions
3. Urinary tract infections, including pyelonephritis
4. Pneumonia and influenza (vaccine-preventable)
5. Cellulitis
6. Iron deficiency anaemia
7. Congestive cardiac failure
8. Ear, nose and throat infections
9. Diabetes complications
10. Convulsions and epilepsy

Consequently, we recommend the following indicators are utilised to prioritise UCC placement:

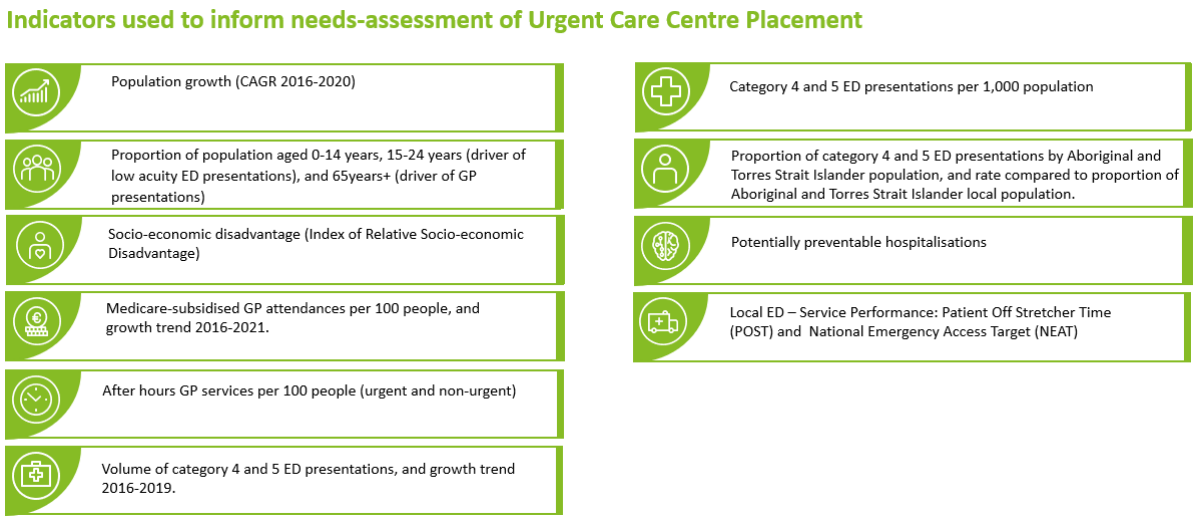
- ***Rates of potentially preventable hospitalisation (PPH).***

Proposed methodology for prioritising UCC investment

Our recommendations on UCC placement have been guided by the key objective of this policy to reduce low acuity ED presentations to both ensure people are being seen in a timely manner within the appropriate setting and improve ED performance.

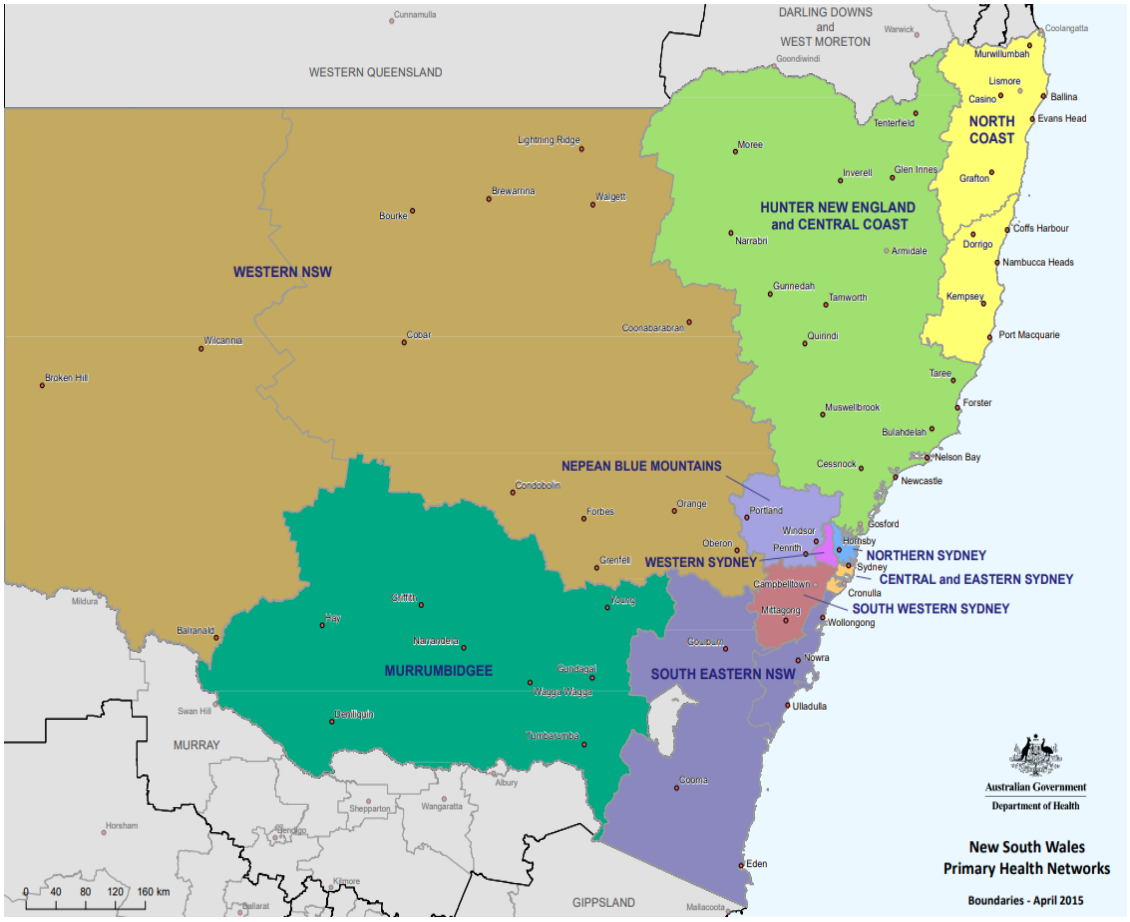
As demonstrated by the evidence in Section 2, the following indicators have been identified as key measures of need to guide appropriate and targeted UCC investment throughout New South Wales (see Figure 5).

Figure 5: Indicators to inform assessment



Each New South Wales PHN (Figure 6) has been assessed against the above indicators to identify priority UCC placement within New South Wales, and also compared to New South Wales and Australian baselines.

Figure 6: New South Wales Primary Health Networks and boundaries



Data Source: Department of Health, New South Wales Primary Health Networks Boundaries (April 2015)

Caveats and Assumptions

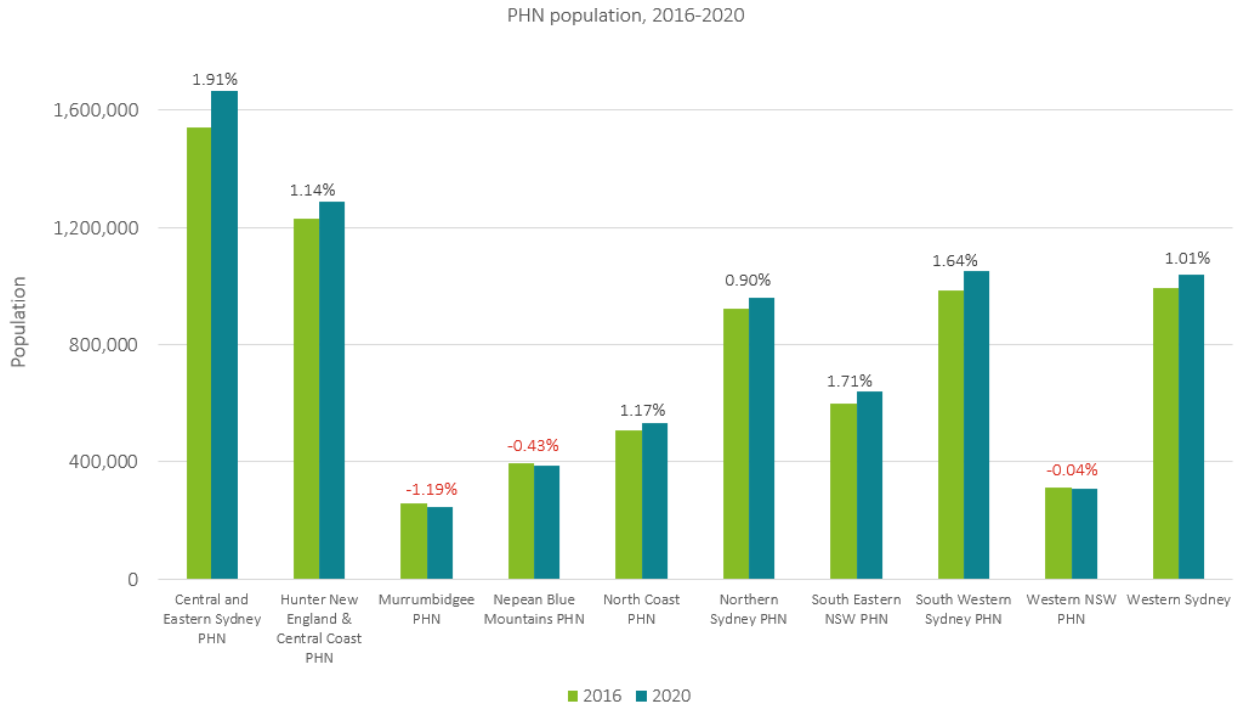
- The low urgency measure is based on triage categories reflecting urgency, not the complexity or severity of a person's health condition or the most appropriate and cost-efficient model of care for that region (AIHW, 2018). Therefore, it is important not to assume that all lower urgency ED presentations can be treated in a primary health care setting.
- Although there are national standards for data on non-admitted patient ED presentations, the way those presentations are defined and counted varies across states and territories, and over time, which may affect comparability across local areas. Nevertheless, this information can be considered alongside other data sources and within the local context of population and service needs.
- During the first half of 2020, there was a general decline in hospital ED presentations, corresponding with the height of the COVID-19 pandemic. As such, trends have also been identified to strengthen the data analysis.

Results of key indicators

Population growth

From 2016 to 2020, the New South Wales population increased by 2.27% compound annual growth rate which is lower than the Australian population growth rate of 2.42% compound annual growth rate. Central and Eastern Sydney PHN, Hunter New England and Central Coast PHN and South Western Sydney PHN, had the highest total population and population growth rates across New South Wales PHNS.

Figure 7: PHN population, 2016-2020

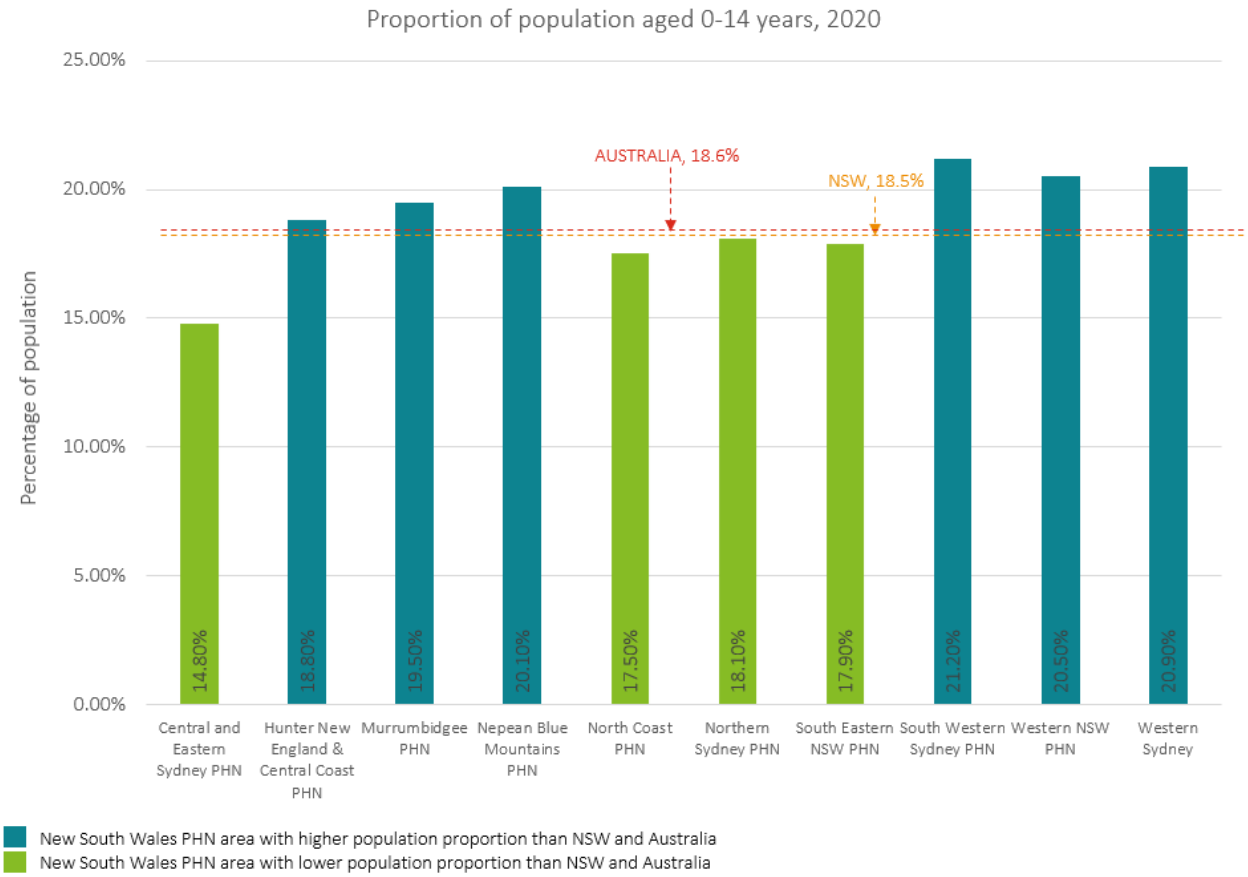


Data source: Social Health Atlas of Australia, 2022

Proportion of population aged 0-14 years

In 2020, six New South Wales PHN areas had a higher proportion of the population aged between 0 and 14 years compared to New South Wales (18.5%) and Australian average (18.6%). South Western Sydney PHN had the highest percentage of its population between 0-14 years (21.2%) whilst Central and Eastern Sydney PHN had the lowest percentage (14.8%).

Figure 8: Proportion of population aged 0-14 years, 2020

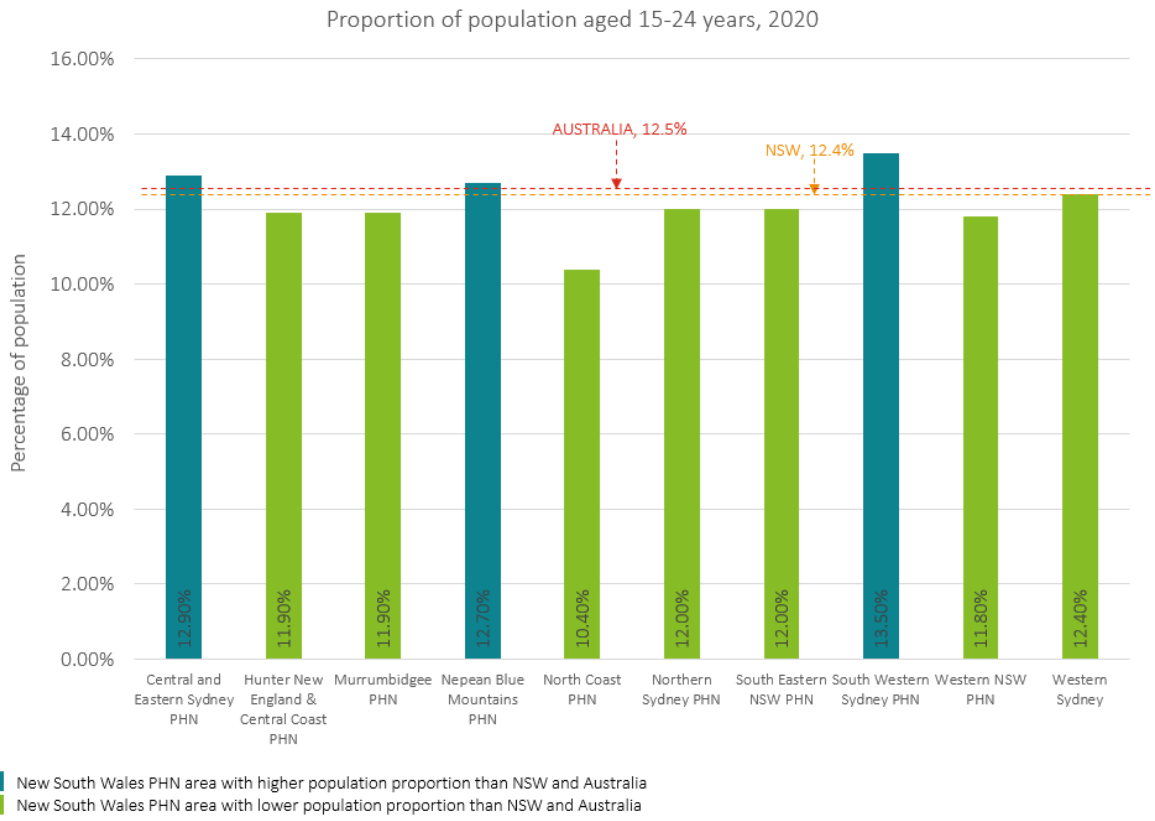


Data source: Social Health Atlas of Australia, 2022

Proportion of population aged 15-24 years

In 2020, seven New South Wales PHN areas had a lower proportion of the population aged between 15 and 24 years compared to New South Wales (12.4%) and Australian averages (12.5%). South Western Sydney PHN had the largest percentage of its population between 14 and 25 years (13.5%) whilst North Coast PHN had the lowest percentage (10.4%).

Figure 9: Proportion of population aged 15-24 years, 2020

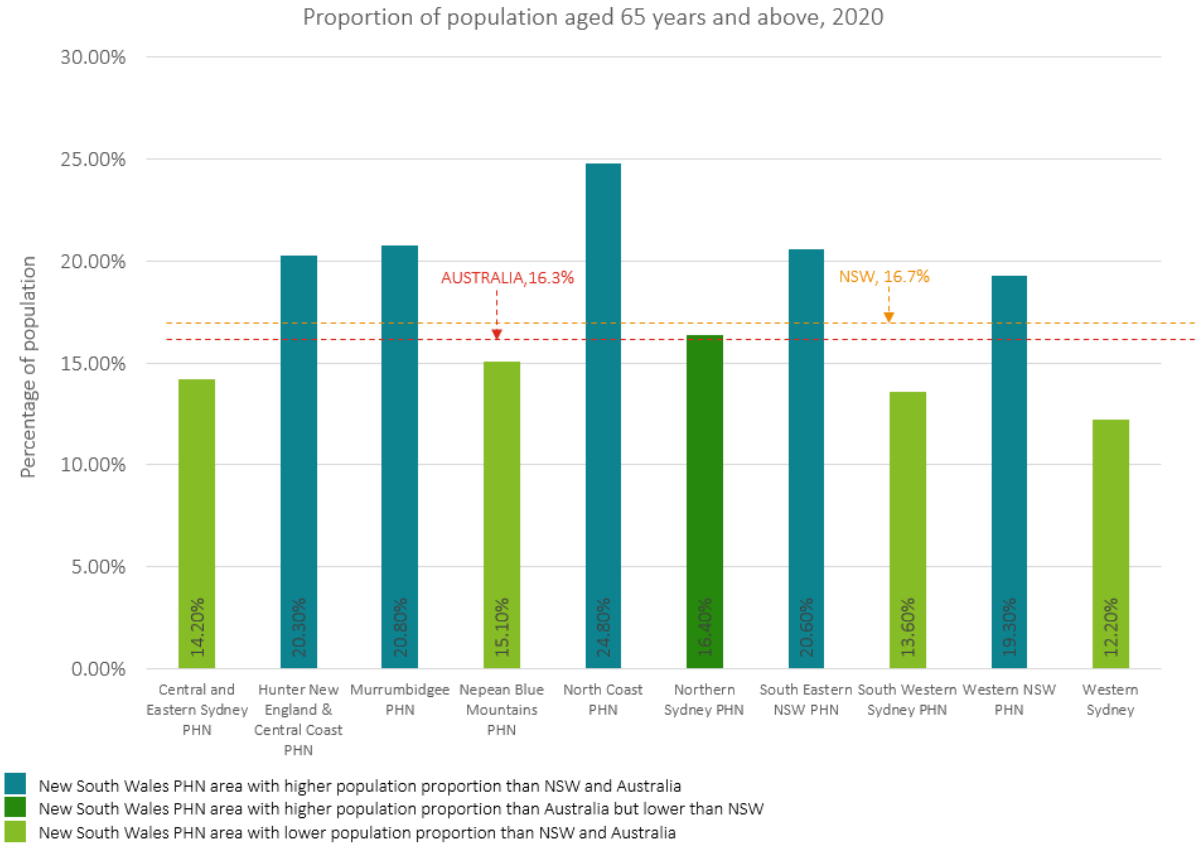


Data source: Social Health Atlas of Australia, 2022

Proportion of population aged 65 years and above

In 2020, half of New South Wales PHN areas had a higher proportion of the population aged 65 years and above compared to New South Wales (16.7%) and Australia (16.3%). North Coast PHN had the largest percentage of its population aged 65 years and above (24.8%).

Figure 10: Proportion of population aged 65 years and above, 2020



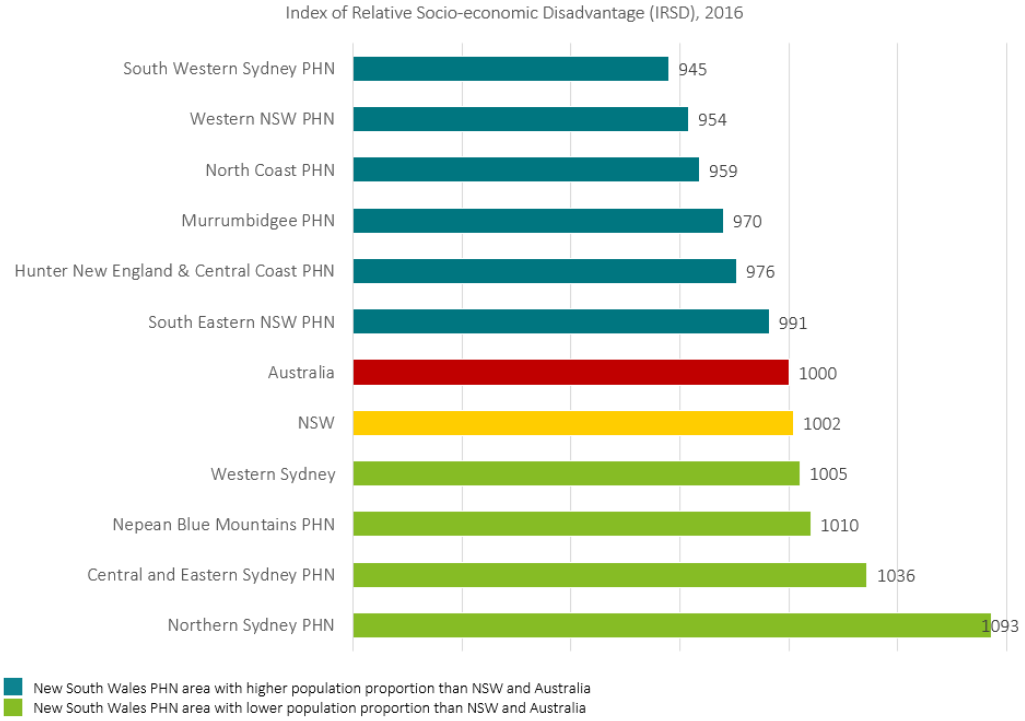
Data source: Social Health Atlas of Australia, 2022

Socio-Economic Disadvantage

In 2016, the majority of New South Wales PHN areas had a lower Index of Relative Socio-economic Disadvantage (IRSD) score than New South Wales (1002) and Australia (1000). A lower IRSD score indicates a higher prevalence of disadvantage in the community. South Western Sydney, Western New South Wales and North Coast PHN areas had the lowest IRSD scores, indicating these communities experienced levels of disadvantage at much higher rates than New South Wales and Australia.

*Please note, IRSD score was used rather than SEIFA scores to represent socio-economic disadvantage due to limitations in publicly available data.

Figure 11: Index of Relative Socio-economic Disadvantage, 2016

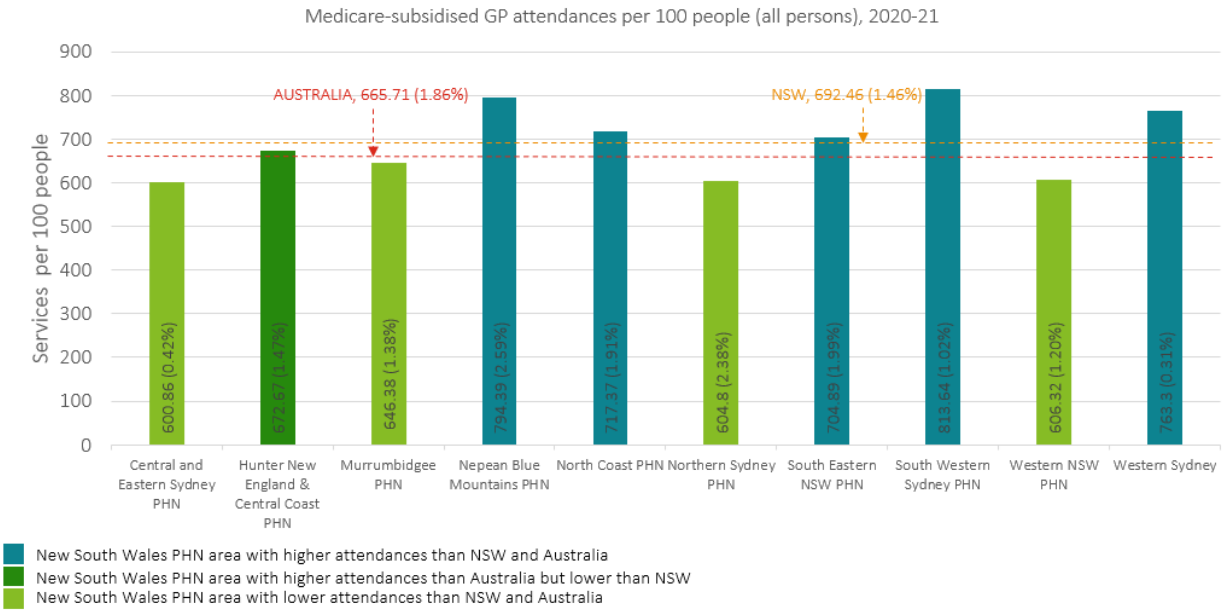


Data source: Social Health Atlas of Australia, 2022

Medicare-subsidised GP attendances per 100 people and growth trend 2016-2021 (all persons)

In 2020-21, half of New South Wales PHN areas had a higher rate of Medicare-subsidised GP attendances per 100 people than New South Wales (692) and Australian average (666). South Western Sydney PHN had the highest rate (814) whilst Central and Eastern Sydney PHN experienced the lowest rate of attendances (601). Between 2015-16 to 2020-21, Nepean Blue Mountains PHN experienced the highest growth (2.59%) in GP attendances per 100 people. Across all PHN areas, people aged 65 years and above experienced the highest rates and growth in GP attendances per 100 people from 2016-2020, with Northern Sydney PHN having a 3.98% growth. General Practitioner Full Time Equivalent (FTE) per 1,000 population was not used as a proxy indicator for access to primary care due to the limitations in data publicly available at a PHN level.

Figure 12: Medicare-subsidised GP attendances per 100 people, 2020-21

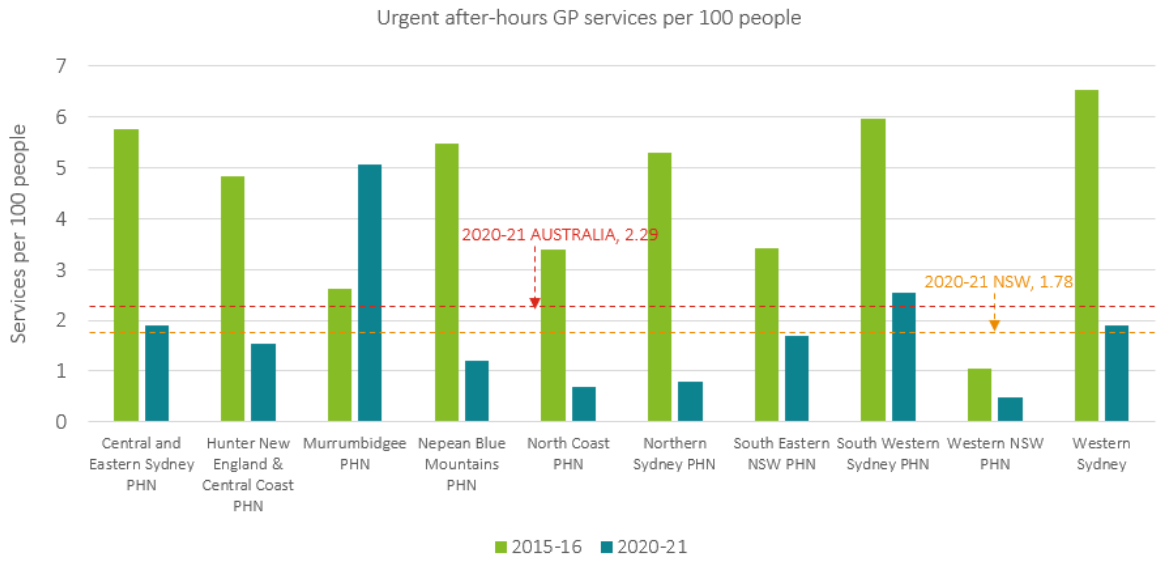


Data source: Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2014-15 to 2020-21

Afterhours GP services per 100 people - urgent

Apart from Murrumbidgee PHN, all other New South Wales PHNs experienced a reduction in the number of urgent afterhours GP services per 100 people from 2015-16 to 2020-21. In 2020-21, Western New South Wales PHN had the lowest number of afterhours GP services per 100 people (0.48) compared to Murrumbidgee PHN (5.06). The Approved Medical Deputising Service (AMDS) program enables GPs who are subject to section 19aa of the Health Insurance Act access to deputise after-hours care for their patients to alternate service providers. Approved participants are granted access to Medicare rebates for providing primary care to patients in an approved AMDS practice, patient home visits, or in residential aged care facilities. This reduces the need for patients to attend an emergency department for after-hours care.

Figure 13: Urgent afterhours GP services per 100 people, 2015-16 to 2020-21

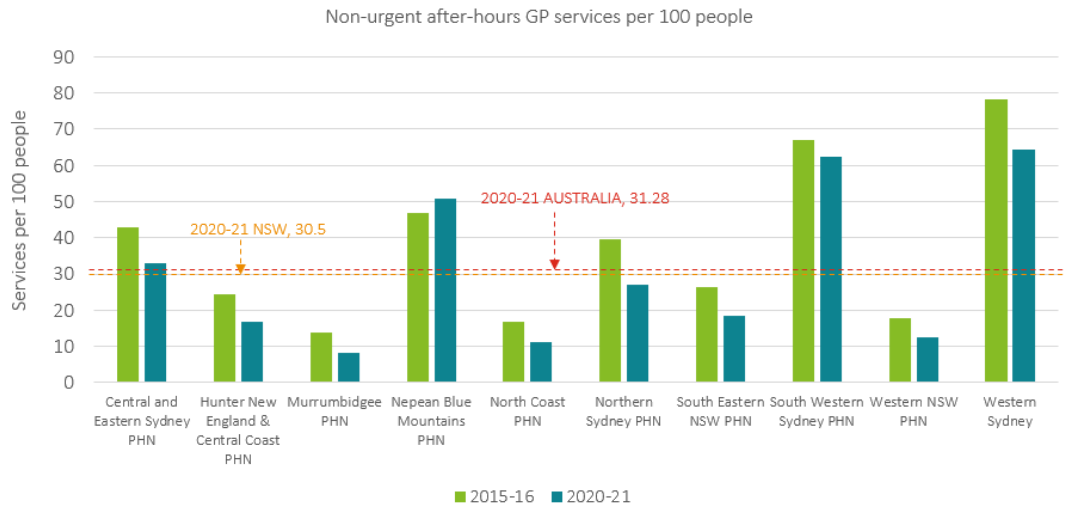


Data source: Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2014-15 to 2020-21. Note: Afterhours GP attendance where patient's medical condition requires urgent assessment to prevent health deterioration and assessment cannot be delayed until next in-hours period.

Afterhours GP services per 100 people – non-urgent

Apart from Nepean Blue Mountains PHN, all other PHNs experienced a reduction in the number of non-urgent afterhours GP services per 100 people from 2015-16 to 2020-21. In 2020-21, Murrumbidgee PHN had the lowest number of afterhours GP services per 100 people (8.3) compared to Western Sydney PHN (64.26).

Figure 14: Non-urgent afterhours GP services per 100 people, 2015-16 to 2020-21

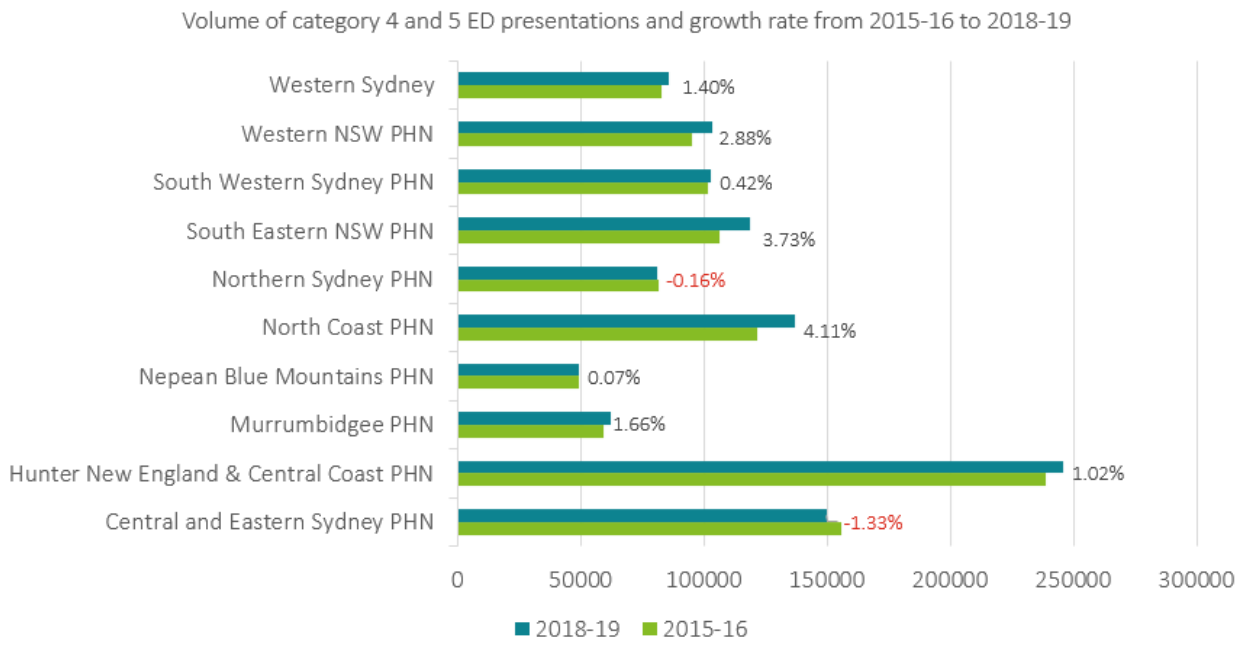


Data source: Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule (MBS) claims data, 2014-15 to 2020-21.

Volume of category 4 and 5 ED presentations, and growth trend 2016-2019

From 2015-16 to 2018-19, New South Wales experienced a 1.36% compound annual growth rate in the number of category 4 and 5 ED presentations, higher than the Australian growth rate of 1.33% compound annual growth rate. Western Sydney, Western New South Wales, South Eastern New South Wales and North Coast PHN areas experienced a higher compound annual growth rate of category 4 and 5 ED presentations than New South Wales and Australia. Hunter New England and Central Coast PHN experienced the highest volume of category 4 and 5 ED presentations of all New South Wales PHNs.

Figure 15: Volume of category 4 and 5 ED presentations and growth rate (2015-16 to 2018-19)

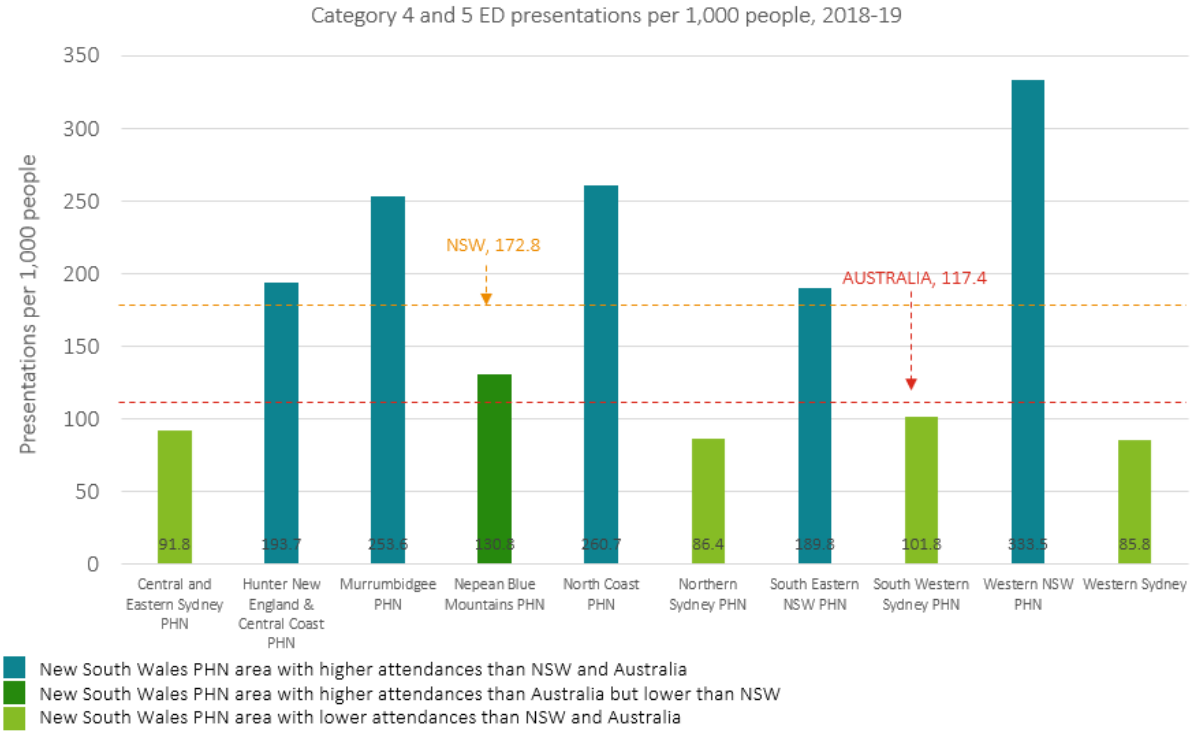


Data source: AIHW National Non-admitted Patient Emergency Department Care Database, 2015–16 through to 2018–19.

Category 4 and 5 ED presentations per 1,000 population

In 2018-19, half of the New South Wales PHN areas had higher rates of category 4 and 5 ED presentations per 1,000 people than New South Wales (172.8) and Australia (117.4). Western Sydney PHN had the lowest number of category 4 and 5 ED presentations (85.8) whilst Western New South Wales PHN had the highest number of presentations (333.5). Western New South Wales PHN had the highest rate of presentations per 1,000 population (333.5).

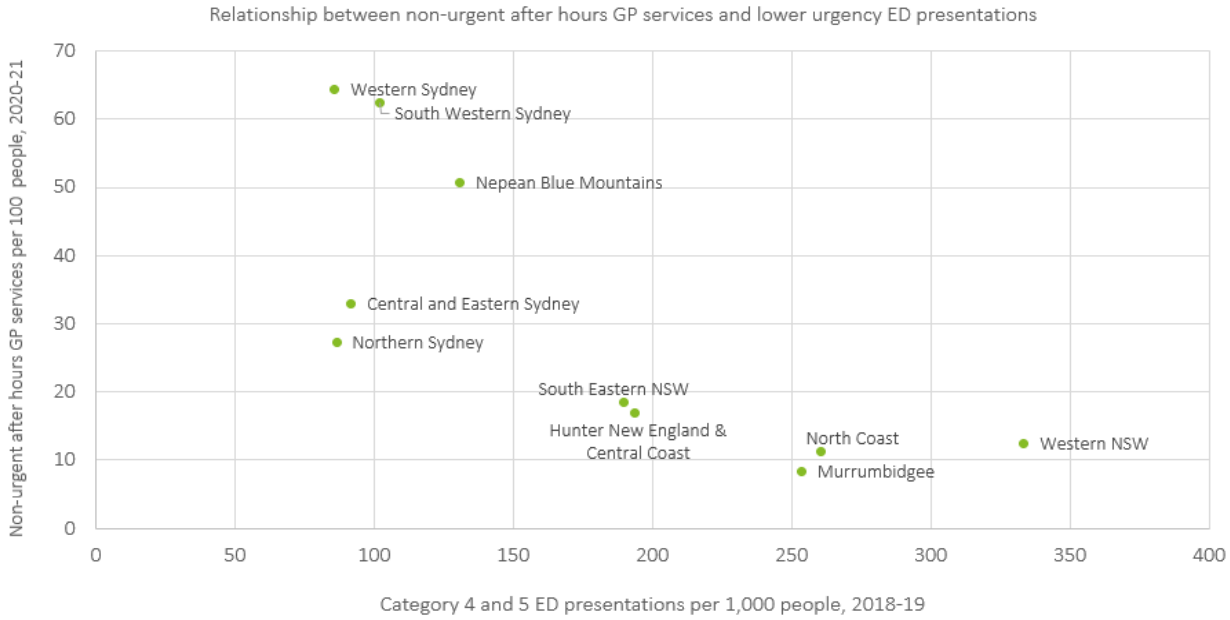
Figure 16: Category 4 and 5 ED presentations per 1,000 people, 2018-19



Data source: Australian Institute of Health and Welfare analysis of the National Non-admitted Patient Emergency Department Care Database, 2015–16, 2016–17, 2017–18 and 2018–19.

There is a clear relationship between less non-urgent afterhours GP services and increased lower urgency ED presentations. This relationship highlights key PHNs requiring UCC investment to reduce low urgency presentations.

Figure 17: Relationship between non-urgent afterhours GP services and lower urgency ED presentations

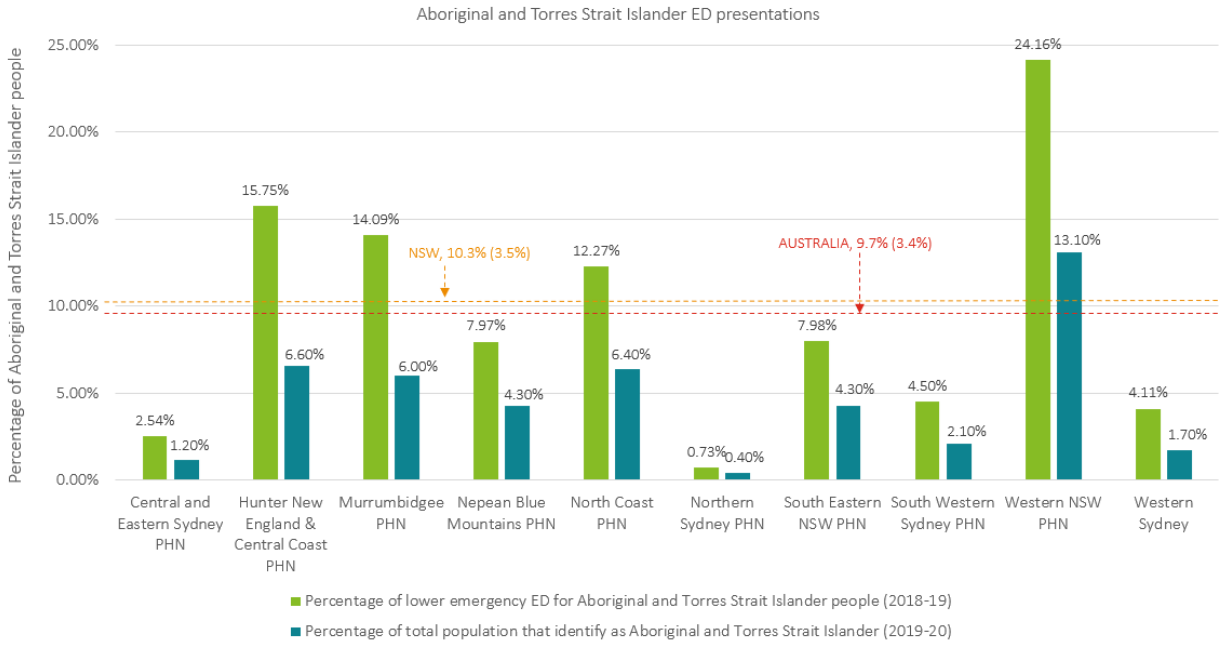


Data source: Australian Institute of Health and Welfare analysis of the National Non-admitted Patient Emergency Department Care Database, 2015–16, 2016–17, 2017–18 and 2018–19. Note: Data in different financial years due to limited publicly available data.

Proportion of category 4 and 5 ED presentations by Aboriginal and Torres Strait Islander people

When compared to the proportion of PHN population that identify as Aboriginal and Torres Strait Islander, all PHN areas had a much higher proportion of lower urgency ED presentations by Aboriginal and Torres Strait Islander people. This indicates a disproportionate impact on this population cohort relating to low urgency ED presentations. Western New South Wales PHN had the highest proportion of Aboriginal and Torres Strait Islander lower urgency ED presentations (24.16%). Aboriginal and Torres Strait Islander people have higher ED presentation rates which is not just attributable to low acuity conditions but to cultural/socio-economic and structural barriers that disproportionately affect this population group

Figure 18: Aboriginal and Torres Strait Islander ED presentations

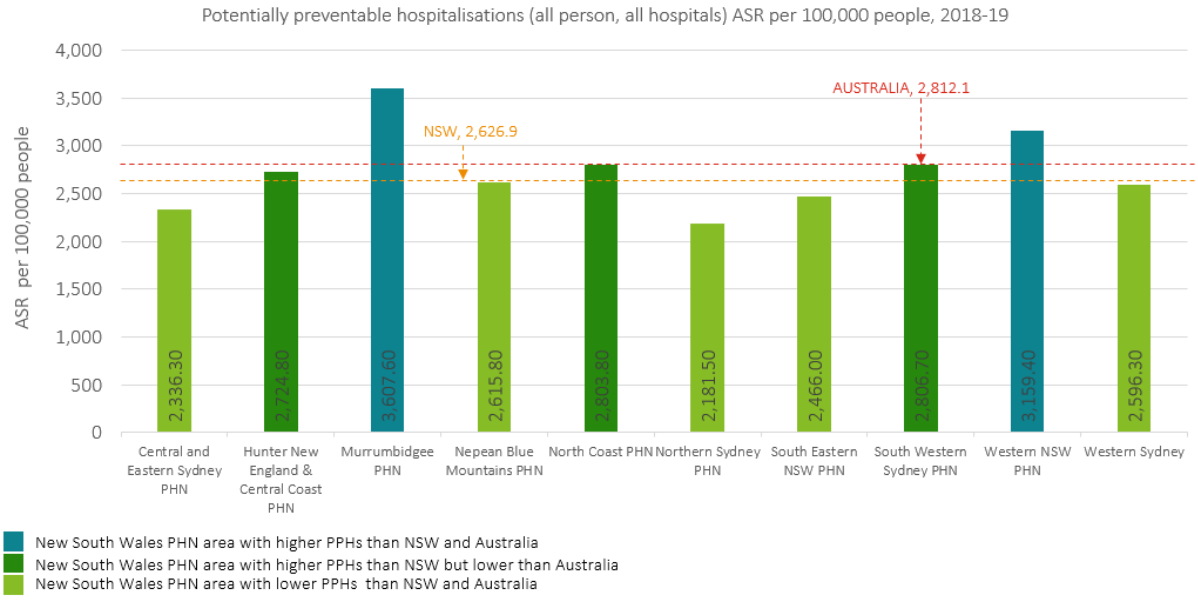


Data source: Aboriginal and Torres Strait Islander Social Health Atlas of Australia Data by Primary Health Networks, published 2022

Potentially preventable hospitalisations

In 2018-19, the majority of New South Wales PHN areas had lower potentially preventable hospitalisations (PPH) ASR per 100,000 people compared to New South Wales and Australian rates. Murrumbidgee and Western New South Wales PHN areas had the highest PPH ASR per 100,000 people. Across all PHN areas, people aged 65 years and above represented the highest percentage of PPHs. Murrumbidgee PHN had a 10,479.6 ASR per 100,000 for people aged 65 years and above.

Figure 19: Potentially Preventable Hospitalisations (all persons, all hospitals) ASR per 100,000 people, 2018-19



Data source: Social Health Atlas of Australia Data by Primary Health Networks, June 2022 Note: These potentially preventable

hospitalisations figures include acute, chronic and vaccine preventable PPHs for all hospitals in the New South Wales region.

Patient Off Stretcher Time (POST) performance across corresponding PHN boundaries

The following table presents the worst performing 10 hospitals in New South Wales for patient off stretcher time (POST), during the period of April 2021 to March 2022. The POST Target is 90% of patients must be transferred from paramedics to ED staff within 30 mins. Four of the worst POST performing hospitals are located in Hunter New England & Central Coast PHN catchment. Wyong Hospital is the worst performing, with 57.9% of patients being transferred within 30 mins.

Table 2: Patient Off Stretcher Time (POST) performance across corresponding PHN boundaries

Hospital	Primary Health Network	Patient Off Stretcher Time
Tamworth Hospital	Hunter New England & Central Coast	72.9%
Gosford Hospital	Hunter New England & Central Coast	70.3%
Calvary Mater Newcastle	Hunter New England & Central Coast	68.1%
Wyong Hospital	Hunter New England & Central Coast	57.9%
Shoalhaven District Memorial Hospital	South Eastern New South Wales	71.9%
Wollongong Hospital	South Eastern NEW SOUTH WALES	73.9%
Belmont Hospital	Hunter New England & Central Coast	72.7%
Nepean Hospital	Nepean Blue Mountains	74.7%
Westmead Hospital	Western Sydney	60.5%
Lismore Base Hospital	North Coast	68.7%

National Emergency Access Target performance across corresponding PHN boundaries

The following table presents the worst performing 10 hospitals in New South Wales for National Emergency Access Target (NEAT), during the period of April 2021 to March 2022. The NEAT Target is that 90% of patients must leave the ED within four hours. Three of the worst NEAT performing hospitals are located in Hunter New England & Central Coast PHN catchment. Westmead Hospital is the worst performing, with only 42.7% of patients leaving the ED within four hours.

Table 3: National Emergency Access Target performance across corresponding PHN boundaries

Hospital	Primary Health Network	National Emergency Access Target
Westmead Hospital	Western Sydney	42.7%
Blacktown Hospital	Western Sydney	48.7%
Liverpool Hospital	South Western Sydney	46.9%
Campbelltown Hospital	South Western Sydney	49.8%
Gosford Hospital	Hunter New England & Central Coast	48.2%
Maitland Hospital	Hunter New England & Central Coast	49.3%
John Hunter Hospital	Hunter New England & Central Coast	51.7%

Wollongong Hospital	South Eastern New South Wales	48.8%
Royal North Shore Hospital	Northern Sydney	52.3%
Nepean Hospital	Nepean Blue Mountains	44.9%

While POST and NEAT performance indicators reflect overall ED operational efficiency, poor performance on these indicators can't be only attributed to low acuity ED presentations. Other factors that contribute to poor ED performance have been excluded from this analysis including complexity of cases, hospital bed block and ED capacity.

Ranking of regions against key indicators

Each PHN has been ranked from highest need (1) to lowest need (10) based on their assessment against all key thirteen indicators of UCC need. None of the data indicators have had a weighting applied but this can be applied if required.

Table 4: Ranking of PHNs against key indicators

	Pop. growth (2016-2020)	Proportion pop. 0-14y (2020)	Proportion pop. 15-24y (2020)	Proportion pop. 65+y (2020)	Socio-economic disadvantage (2016)	GP attendances per 100 (2020-21)	Non-urgent afterhours GP services per 100 (2020-21)	Volume cat 4/5 ED (2018-19)	Cat 4/5 ED presentations per 1,000 (2018-19)	Prop. cat4/5 ED by Aboriginal & Torres Strait of total (18-19)	PPH (all)	POST (04/21-03/22)	NEAT (04/21-03/22)	**Average Score**
Western New South Wales	8	3	9	5	2	3	3	5	1	1	2	9	10	4.69
South Western Sydney	3	1	1	9	1	10	9	6	7	7	3	3	2	4.77
Hunter New England & Central Coast	5	6	7	4	5	5	4	1	4	2	5	6	8	4.77
Murrumbidgee	10	5	8	2	4	4	1	9	3	3	1	7	5	4.77
North Coast	4	9	10	1	3	7	2	3	2	4	4	5	9	4.85
South Eastern New South Wales	2	8	6	3	6	6	5	4	5	5	8	4	6	5.23
Central and Eastern Sydney	1	10	2	8	9	1	7	2	8	9	9	2	4	5.54
Western Sydney	7	2	4	10	7	8	10	7	10	8	7	1	1	6.31
Nepean Blue Mountains	9	4	3	7	8	9	8	10	6	6	6	8	3	6.69
Northern Sydney	6	7	5	6	10	2	6	8	9	10	10	10	7	7.38

Note: Pop. is population; PPH is potentially preventable hospitalisation; POST is patient off stretcher time 12month average; NEAT is National Emergency Access Target 12 month average; Pres. Is presentation; FTE is full time equivalent. Note: Total volume of category 4 and 5 ED presentations and ED presentations per 1,000 people were both included as key indicators for PHN ranking to account for population discrepancies in different PHN areas. Presentations per 1000 people allows for a consistent measure of performance.

Conclusion

Not only is the ED a more expensive form of service provision, avoidable low-urgency presentations are also less likely to result in the development of good health behaviour and a positive life-long journey in primary care, impacting longer-term health outcomes for patients. Evidently, the ongoing application of traditional primary care models can only be expected to result in more uncomfortable and unplanned increases in future demand, as the health needs of the population (particularly younger and more vulnerable cohorts) go unmet in primary care, resulting in poor longer-term outcomes and avoidable ED presentations.

Through commissioning services that rigorously target key areas of demand and are prioritised based on local population needs, this UCC policy will optimise likelihood of return on investment through reduced avoidable ED presentations, increased ED performance, improved patient outcomes and better integration of primary care with the broader health ecosystem. As such, we advocate that policy and investment decisions on UCC placement in New South Wales align with the recommendations in this Position Paper.

Appendix 1 – SA3 prioritisation

The geographical boundaries of some New South Wales PHNs are large, with each PHN consisting of different communities with different levels of health and service needs. As such, we have further identified priority areas of need by SA3 level for key indicators. Not all of the indicators available for the PHN ranking are available by SA3 hence why these indicators are listed separately.

This ranking can be used to assist with prioritisation within each region.

Five key indicators were utilised to assess specific SA3 areas of need. These indicators were selected based on:

1. identifying key SA3 areas with high demand for low urgency ED presentations (Cat 4 and 5 ED presentations per 1,000 people)
2. identifying key SA3 areas with a large population of the target cohort (0-14 years)
3. identifying key SA3 areas with a large population of the target cohort (15-24 years)
4. identifying key SA3 areas with particularly vulnerable populations (socioeconomic disadvantage)
5. Population growth (2016-2020).

Assessment of priority SA3 areas based on each specific indicator is detailed below.

Table 5: Ranking of top 38 SA3 areas based on category 4 and 5 ED presentations per 1,000 people

Category 4 and 5 ED presentations per 1,000 people ***New South Wales (172.8)***
1. Kempsey - Nambucca (431.1) (North Coast)
2. Clarence Valley (371.2) (North Coast)
3. Tamworth - Gunnedah (359.3) (Hunter New England & Central Coast)
4. Richmond Valley - Hinterland (337.1) (North Coast)
5. Lithgow - Mudgee (322.8) (Nepean Blue Mountains)
6. Upper Hunter (319.3) (Hunter New England & Central Coast)
7. South Coast (305) (South Eastern New South Wales)
8. Dubbo (298.7) (Western New South Wales)
9. Moree - Narrabri (298) (Hunter New England & Central Coast)
10. Snowy Mountains (292.8) (South Eastern New South Wales)
11. Griffith - Murrumbidgee (West) (291.6) (Murrumbidgee)
12. Upper Murray exc. Albury (276.7) (Murrumbidgee)
13. Lower Hunter (273.4) (Hunter New England & Central Coast)
14. Orange (262.8) (Western New South Wales)
15. Lower Murray (258.4) (Murrumbidgee)
16. Goulburn - Mulwaree (257.4) (South Eastern New South Wales)
17. Armidale (257) (Hunter New England & Central Coast)
18. Bathurst (251.8) (Western New South Wales)
19. Queanbeyan (246.8) (South Eastern New South Wales)
20. Inverell - Tenterfield (241.3) (Hunter New England & Central Coast)
21. Young - Yass (240.8) (South Eastern New South Wales)
22. Richmond Valley - Coastal (238.1) (North Coast)
23. Wagga Wagga (226.9) (Murrumbidgee)
24. Tumut - Tumbarumba (222.2) (Murrumbidgee)
25. Tweed Valley (217.1) (North Coast)
26. Shoalhaven (207.7) (South Eastern New South Wales)

27. Taree - Gloucester (206.6) (Hunter New England & Central Coast)
28. Coffs Harbour (202.2) (North Coast)
29. Wyong (195.6) (Hunter New England & Central Coast)
30. Maitland (193.4) (Hunter New England & Central Coast)
31. Lake Macquarie - East (168.5) (Hunter New England & Central Coast)
32. Port Macquarie (162.4) (North Coast)
33. Port Stephens (160.6) (Hunter New England & Central Coast)
34. Newcastle (155.9) (Hunter New England & Central Coast)
35. Lake Macquarie - West (153) (Hunter New England & Central Coast)
36. Kiama - Shellharbour (148.8) (South Eastern New South Wales)
37. Richmond - Windsor (148.3) (Nepean Blue Mountains)
38. Hawkesbury (139.2) (Nepean Blue Mountains)

Table 6: Ranking of top 38 SA3 areas based on the proportion of the population aged 0-14 years

Proportion of the population aged 0-14 years ***New South Wales (18.5%)***
1. Bourke - Cobar - Coonamble(25.8)(Western New South Wales)
2. Camden(24.7)(South Western Sydney)
3. Lachlan Valley(23.3)(Western New South Wales)
4. Blacktown(22.8)(Western Sydney)
5. Moree-Narrabri(22.7)(Hunter New England and Central Coast)
6. Upper Hunter(22.6)(Hunter New England and Central Coast)
7. Liverpool(22.3)(South Western Sydney)
8. Tamworth - Gunnedah(22.3)(Hunter New England and Central Coast)
9. Campbelltown(22.2)(South Western Sydney)
10. Orange(22)(Western New South Wales)
11. Lower Hunter(21.8)(Hunter New England and Central Coast)
12. Goulburn-Mulwaree(21.7)(South Western Sydney)
13. Dubbo(21.6)(Western New South Wales)
14. Maitland(21.6)(Hunter New England and Central Coast)
15. Griffith - Murrumbidgee (West)(21.6)(Murrumbidgee)
16. Broken Hill and Far West(21.5)(Western New South Wales)
17. Penrith(21.3)(Nepean Blue Mountains)
18. Albury(21.2)(Murrumbidgee)
19. Dural - Wisemans Ferry(21)(Western Sydney)
20. Young-Yass(20.7)(South Eastern New South Wales)
21. Canterbury(20.2)(Central and Eastern Sydney)
22. Lower Murray(20.1)(Western New South Wales)
23. Queanbeyan(20)(South Eastern New South Wales)
24. Inverell-Tenterfield(20)(Hunter New England and Central Coast)
25. Kiama- Shellharbour(19.7)(South Eastern New South Wales)
26. Wagga Wagga(19.6)(Murrumbidgee)
27. Hawkesbury(19.6)(Nepean Blue Mountains)
28. Ku-ring-gai(19.6)(Northern Sydney)
29. Upper Murray exc. Albury(19.5)(Murrumbidgee)
30. Hornsby(19.5)(Northern Sydney)
31. Bathurst(19.1)(Western New South Wales)
32. Chatswood-Lane Cove(19.1)(Northern Sydney)
33. Tumut-Tumbarumba(19)(Murrumbidgee)

34. Lake Macquarie-West(18.9)(Hunter New England and Central Coast)
35. Pittwater(18.9)(Northern Sydney)
36. Richmond Valley-Hinterland(18.8)(North Coast)
37. Sutherland-Menai-Heathcote(18.8)(Central and Eastern Sydney)
38. Coffs Harbour(18.8)(North Coast)

Table 7: Ranking of top: 38 SA3 areas based on the proportion of the population aged 15-24 years

Proportion of the population aged 15-24 years ***New South Wales (12.4%)***
1. Armidale (18.7) (Hunter New England and Central Coast)
2. Eastern Suburbs - South (16.3) (Central and Eastern Sydney)
3. Strathfield - Burwood - Ashfield (16.2) (Central and Eastern Sydney)
4. North Sydney - Mosman (15.9) (Northern Sydney)
5. Bathurst (15) (Western New South Wales)
6. Ryde-Hunters Hill (14.8) (Northern Sydney)
7. Fairfield (14.4) (South Western Sydney)
8. Ku-ring-gai (14.3) (Northern Sydney)
9. Wagga Wagga (14.3) (Murrumbidgee)
10. New Castle (14.1) (Hunter New England and Central Coast)
11. Wollongong (14.1) (South Eastern New South Wales)
12. Liverpool (14) (South Western Sydney)
13. Griffith-Murrumbidgee (West) (13.7) (Murrumbidgee)
14. Hawkesbury (13.7) (Nepean Blue Mountains)
15. Dural-Wisemans Ferry (13.6) (Western Sydney)
16. Wollondilly (13.4) (South Western Sydney)
17. Upper Murray exc. Albury (13.3) (Murrumbidgee)
18. Campbelltown (13.1) (South Western Sydney)
19. Kiama-Shellharbour (13.1) (South Eastern New South Wales)
20. Penrith (13) (Nepean Blue Mountains)
21. Blacktown (13) (Western Sydney)
22. Hornsby (12.9) (Northern Sydney)
23. Canterbury (12.9) (Central and Eastern Sydney)
24. Camden (12.9) (South Western Sydney)
25. Lachlan Valley (12.8) (Western New South Wales)
26. Maitland (12.3) (Hunter New England and Central Coast)
27. Lower Murray (12.2) (Murrumbidgee)
28. Kogarah - Rockdale (12.1) (Central and Eastern Sydney)
29. Inverell-Tenterfield (12.1) (Hunter New England and Central Coast)
30. Dubbo (12) (Western New South Wales)
31. Sutherland-Menai-Heathcote (12) (Central and Eastern Sydney)
32. Tamworth-Gunnedah (12) (Hunter New England and Central Coast)
33. Orange (12) (Western New South Wales)
34. Richmond Valley-Hinterland (12) (North Coast)
35. Blue Mountains (11.9) (Nepean Blue Mountains)
36. Lower Hunter (11.8) (Hunter New England and Central Coast)
37. Southern Highlands (11.8) (South Western Sydney)
38. Gosford (11.8) (Hunter New England and Central Coast)

Table 8: Ranking of top 38 SA3 areas based on population growth (2016-2020)

Population growth (2016-2020) ***New South Wales (0.227 CAGR)***
1. Camden(0.084)(South Western Sydney)
2. North Sydney - Mosman(0.046)(Northern Sydney)
3. Botany(0.043)(Central and Eastern Sydney)
4. Dural - Wisemans Ferry(0.04)(Western Sydney)
5. Strathfield - Burwood - Ashfield(0.039)(Central and Eastern Sydney)
6. Parramatta(0.037)(Western Sydney)
7. Chatswood - Lane Cove(0.036)(Northern Sydney)
8. Kogarah - Rockdale(0.035)(Central and Eastern Sydney)
9. Ryde - Hunters Hill(0.034)(Northern Sydney)
10. Blacktown(0.032)(Western Sydney)
11. Richmond Valley- Coastal(0.032)(North Coast)
12. Maitland(0.031)(Hunter New England and Central Coast)
13. Liverpool(0.031)(South Western Sydney)
14. Goulburn-Mulwaree(0.029)(South Western Sydney)
15. Eastern Suburbs - South(0.027)(Central and Eastern Sydney)
16. Quenbeyan(0.027)(South Eastern New South Wales)
17. Eastern Suburbs - North(0.027)(Central and Eastern Sydney)
18. Campbelltown(0.026)(South Western Sydney)
19. Canada Bay(0.026)(Central and Eastern Sydney)
20. Penrith(0.026)(Nepean Blue Mountains)
21. Kiama- Shellharbour(0.025)(South Eastern New South Wales)
22. Lower Hunter(0.025)(Hunter New England and Central Coast)
23. Canterbury(0.024)(Central and Eastern Sydney)
24. Port Macquarie(0.023)(North Coast)
25. Pittwater(0.02)(Northern Sydney)
26. Southern Highlands(0.02)(South Western Sydney)
27. Ku-ring-gai(0.02)(Northern Sydney)
28. Dubbo(0.019)(Western New South Wales)
29. Wollongong(0.019)(South Eastern New South Wales)
30. Tweed Valley(0.019)(North Coast)
31. Shoalhaven(0.018)(South Eastern New South Wales)
32. Young-Yass(0.018)(South Eastern New South Wales)
33. Newcastle(0.017)(Hunter New England and Central Coast)
34. Griffith-Murrumbidgee (West)(0.016)(Murrumbidgee)
35. Coffs Harbour(0.016)(North Coast)
36. Bathurst(0.016)(Western New South Wales)
37. Tumut-Tumbarumba(0.015)(Murrumbidgee)
38. Fairfield(0.015)(South Western Sydney)

Table 9: Ranking of top 38 SA3 areas based the Index of Relative Socio-economic Disadvantage (IRSD)

Socio-economic disadvantage (IRSD) ***New South Wales (1002)***
1. Bourke - Cobar - Coonamble (828) (Western New South Wales)
2. Fairfield (857) (South Western Sydney)

3. Broken Hill and Far West (876) (Western New South Wales)
4. Kempsey-Nambucca (887) (North Coast)
5. Richmond Valley-Hinterland (899) (North Coast)
6. Inverell-Tentefield (909) (Hunter New England and Central Coast)
7. Dubbo (911) (Western New South Wales)
8. Tamworth-Gunnedah (914) (Hunter New England and Central Coast)
9. Moree-Narrabri (920) (Hunter New England and Central Coast)
10. Lachlan Valley (921) (Western New South Wales)
11. Lithgow-Mudgee (922) (Nepean Blue Mountains)
12. Lower Hunter (926) (Hunter New England and Central Coast)
13. Clarence Valley (926) (North Coast)
14. Taree-Gloucester (928) (Hunter New England and Central Coast)
15. Griffith-Murrumbidgee (West) (929) (Murrumbidgee)
16. Upper Hunter (930) (Hunter New England and Central Coast)
17. Canterbury (937) (Central and Eastern Sydney)
18. Lower Murray (939) (Murrumbidgee)
19. Wagga Wagga (941) (Murrumbidgee)
20. Upper Murray exc. Albury (948) (Murrumbidgee)
21. Orange (951) (Murrumbidgee)
22. Campbelltown (951) (South Western Sydney)
23. Tumut-Tumbarumba (951) (Murrumbidgee)
24. Liverpool (952) (South Western Sydney)
25. Coffs Harbour (960) (North Coast)
26. Goulburn-Mulwaree (961) (South Eastern New South Wales)
27. South Coast (963) (South Eastern New South Wales)
28. Shoalhaven (964) (South Eastern New South Wales)
29. Bathurst (966) (Western New South Wales)
30. Tweed Valley (973) (North Coast)
31. Kiama-Shellharbour (976) (South Eastern New South Wales)
32. Port Macquarie (976) (North Coast)
33. Port Stephens (979) (Hunter New England and Central Coast)
34. Armidale (980) (Hunter New England and Central Coast)
35. Maitland (985) (Hunter New England and Central Coast)
36. Blacktown (986) (Western Sydney)
37. Gosford (988) (Hunter New England and Central Coast)
38. Wollongong (989) (South Eastern New South Wales)

Table 20: SA3 assessment against prioritisation indicators

SA3 areas were assessed against the selected five key indicators. SA3 areas with the lowest average score have the highest health needs for UCC placement.

SA3 area	SA3 Prioritisation Indicators					
	Population growth	Proportion population 0-14 years	Proportion population 15-24 years	Socioeconomic disadvantage	Cat 4/5 ED presentations per 1,000 population	Average score
Bourke-Cobar-Coonamble		1		1		0.4
Botany	3					0.6

SA3 area	SA3 Prioritisation Indicators					
	Population growth	Proportion population 0-14 years	Proportion population 15-24 years	Socioeconomic disadvantage	Cat 4/5 ED presentations per 1,000 population	Average score
Kempsey-Nambucca				4	1	1
North Sydney – Mosman	2		4			1.2
Parramatta	6					1.2
Strathfield - Burwood - Ashfield	5		3			1.6
Snowy Mountains					10	2
Ryde-Hunters Hill	9		6			3
Clarence Valley				13	2	3
Lithgow-Mudgee				11	5	3.2
Wollondilly			16			3.2
Eastern Suburbs – South	15		2			3.4
Eastern Suburbs - North	17					3.4
Albury		18				3.6
Canada Bay	19					3.8
Broken Hill and Far West		16		3		3.8
Moree-Narrabi		5		9	9	4.6
Camden	1	2	24			5.4
Upper Hunter		6		16	6	5.6
Wyong					29	5.8
Lake Macquarie-East					31	6.2
Richmond Valley-Coastal	11				22	6.6
South Coast				27	7	6.8
Blue Mountains			35			7
Kogarah-Rockdale	8		28			7.2
Richmond-Windsor					37	7.4
Lachlan Valley		3	25	10		7.6

SA3 area	SA3 Prioritisation Indicators					
	Population growth	Proportion population 0-14 years	Proportion population 15-24 years	Socioeconomic disadvantage	Cat 4/5 ED presentations per 1,000 population	Average score
Dural - Wisemans Ferry	4	19	15			7.6
Chatswood - Lane Cove	7	32				7.8
Taree-Gloucester				14	27	8.2
Fairfield	38		7	2		9.4
Tamworth-Gunnedah		8	32	8	3	10.2
Hornsby		30	22			10.4
Armidale			1	34	17	10.4
Liverpool	13	7	12	24		11.2
Penrith	20	17	20			11.4
Quenbeyan	16	23			19	11.6
Pittwater	25	35				12
Southern Highlands	26		37			12.6
Ku-ring-gai	27	28	8			12.6
Port Stephens				33	33	13.2
Campbelltown	18	9	18	22		13.4
Goulburn-Mulwaree	14	12		26	16	13.6
Sutherland-Menai-Heathcote		37	31			13.6
Lake Macquarie West		34			35	13.8
Blacktown	10	4	21	36		14.2
Young-Yass	32	20			21	14.6
Gosford			38	37		15
Newcastle	33		10		34	15.4
Wagga Wagga		26	9	19	23	15.4
Wollongong	29		11	38		15.6
Orange		10	33	21	14	15.6
Upper Murray exc Albury		29	17	20	12	15.6
Inverell-Tenterfield		24	29	6	20	15.8

SA3 area	SA3 Prioritisation Indicators					
	Population growth	Proportion population 0-14 years	Proportion population 15-24 years	Socioeconomic disadvantage	Cat 4/5 ED presentations per 1,000 population	Average score
Hawkesbury		27	14		38	15.8
Richmond Valley-Hinterland		36	34	5	4	15.8
Lower Murray		22	27	18	15	16.4
Canterbury	23	21	23	17		16.8
Tweed Valley	30			30	25	17
Shoalhaven	31			28	26	17
Dubbo	28	13	30	7	8	17.2
Port Macquarie	24			32	32	17.6
Griffith-Murrumbidgee	34	15	13	15	11	17.6
Lower Hunter	22	11	36	12	13	18.8
Maitland	12	14	26	35	30	23.4
Tumut-Tumbarumba	37	33		23	24	23.4
Bathurst	36	31	5	29	18	23.8
Coffs Harbour	35	38		25	28	25.2
Kiama-Shellharbour	21	25	19	31	36	26.4

Note: No weighting has been applied to ranking.

Appendix 2 - Alignment with government priorities

The ***Productivity Commission Shifting the Dial – 5 Year Productivity Review*** demonstrated how delivering health services more efficiently and effectively is key to fostering a stronger economy. This review recommended patient-centred and integrated care initiatives that are closely aligned with this Position Paper's evidence based approach to prioritisation of UCC placement.
The ***New South Wales Premier Priorities*** set specific ambitious targets with the purpose of delivering on the government's key policy priorities by 2023. Two of these priorities specifically align with the UCC policy and should be considered as part of implementation planning:

1. Improving outpatient and community care: target to reduce preventable visits to hospital by 5% through to 2023 by caring for people in the community.
2. Improving hospital service levels: targets relating to patients commencing treatment on time.

Through alleviating demand of avoidable low urgency related ED presentations, this will enable hospital services to divert more resources to higher acuity presentations and subsequently close the gap needed to achieve New South Wales Premier Priority targets (see Table 3).

Table 31: New South Wales Priority Targets

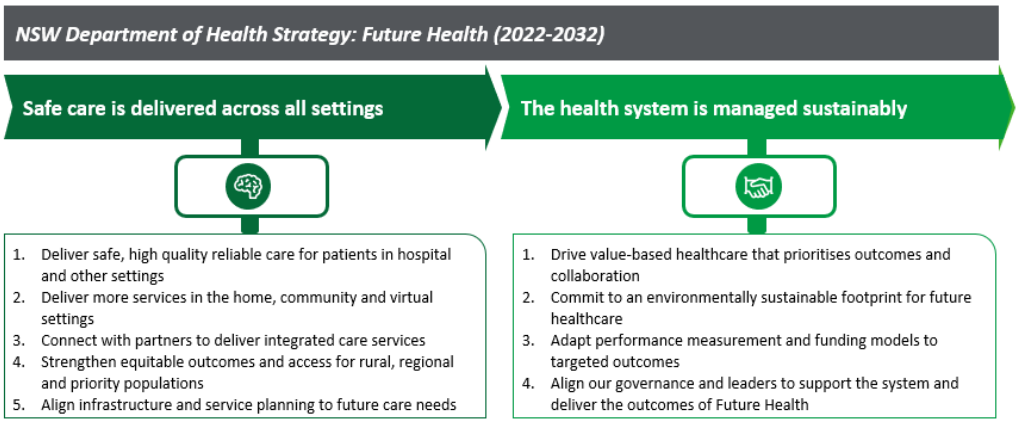
Triage Category	Time to treatment	National target % of patients 'seen on time'	New South Wales Premier Priority targets	New South Wales performance 2020-21
Triage 1	Immediate	100%	100%	100%
Triage 2	10 minutes	80%	95%	79%
Triage 3	30 minutes	75%	85%	75%
Triage 4	60 minutes	70%	70%*	n/a
Triage 5	120 minutes	70%	70%*	n/a

*Not included in Premiers Target

The ***New South Wales Department of Health Strategy: Future Health (2022-2032)*** outlines 6 key strategic outcomes to guide the next decade of care in New South Wales. Two of these strategic outcomes align with the UCC prioritisation approach put forward in this position paper (

Figure 20).

Figure 20: Two of the New South Wales Department of Health Strategic outcomes align with this Position Paper's recommendations



Appendix 3 - Implementation considerations

Previous trials and pilots of primary care reform have yielded important lessons which should be considered to optimise the successful implementation of UCC. In particular, evaluations of the *Health Care Homes trial (2022)* and the *PHN Afterhours Program* (Fig 21) have several highly relevant feedback themes which align with our UCC implementation recommendations below.

R1. Ensure sustainability and market resilience of participating and surrounding General Practices

1.1 Provide comprehensive guidance and other relevant information to practices early, to enable adequate preparation for change.
1.2 Ensure GPs within participating practices have been adequately informed about the initiative and support implementation.
1.3 Stage implementation to enable refinement of processes and systems, as well as apply lessons from earlier cohorts to later cohorts.
1.4 Provide practical training materials and facilitate interactions with peer practices (e.g. communities of practice, leverage PHN involvement).
1.5 Provide clarity on what is included and excluded from the associated funding, rather than GPs and practices trying to interpret this. These distinctions may also not be required, and instead handled through payment design.

R2. Incentivise General Practitioner and Practice participation

2.1 Australia has a range of financial incentives to encourage GPs to organise and provide afterhours primary care (i.e. PIP, MBS and PHN funding, Afterhours GP helpline – see ***Appendix 1***). However, this model needs to provide certainty of funding and flexibility to deliver services in a different way.
2.2 Set-up costs can be reduced by tackling some issues system-wide rather than each practice resolving the issues individually.
2.3 Stipulate targets for patient and GP participation, to achieve an appropriate scale and whole-of-practice involvement and commitment to change. The OECD considers that the most effective way to improve primary care service availability afterhours is to mandate the participation of GPs. Most countries require some level of participation, for example, as a requirement for continuing professional registration.

R3. Align data sources and KPIs to ensure effective evaluation and reinvestment

3.1 Systematically improve the consistency with which health conditions are recorded within practice clinical management systems to derive quality of care and performance indicators.
3.2 Establish a common set of outcome measures that assess efficiency, effectiveness and accessibility of this model of care.

R4. Engaging patients, carers, and families

The afterhours system is confusing for many consumers, arising from the number of options available, local variations, fluctuation in availably of options across different afterhours periods and changes in service availability. There is no evidence that the situation has improved greatly from the 2014 Jackson review of afterhours services where consumers generally were seen to have limited awareness of the services available to them in the afterhours period or how to access the most appropriate care (Jackson, 2014).

4.1 Provide practices with guidance on how to communicate benefits of this model to the local community to optimise participation and build confidence health needs will be met.
4.2 Adopt specific strategies to recruit patients who are less motivated to engage with this model yet are likely to yield the most benefits from this model (e.g. frequent ED presenters).
4.3 If multiple entry points continue to be a feature of the system, then there is a need to simplify and support GPs to communicate clearly how services are accessed and how much they cost, as well as use of system navigators to support patients.
4.4 Remove barriers to participation by young people, through both in person and digital options. This includes determining the continuing role of telehealth options in afterhours care.
4.5 Remove barriers to participation by Aboriginal and Torres Strait Islander people through ensuring cultural safety of proposed model of care.

R5. Increase access to primary care services generally

5.1 The afterhours system cannot compensate effectively for shortcomings in access to primary care generally – this must be considered as part of the overarching investment goals. This includes consideration of specific primary health care needs for vulnerable population, such as homeless people, people living in residential aged care and people with disabilities.

R6. Appropriate resourcing for / access to supporting services infrastructure and equipment

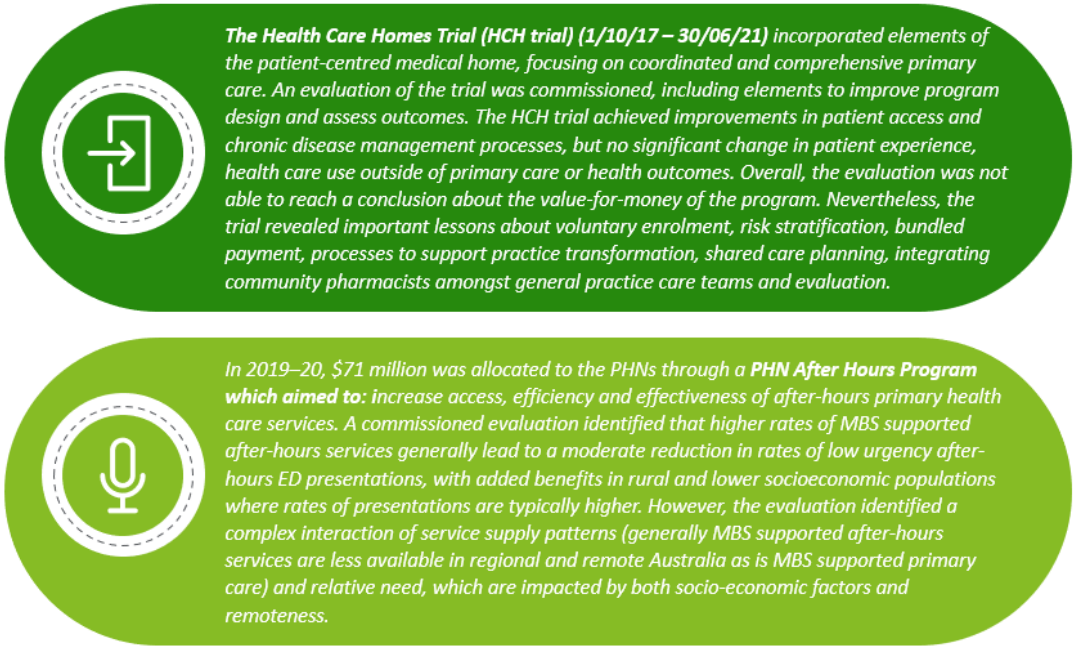
6.1 In order to achieve intended benefits of ED diversion, appropriate infrastructure to support afterhours GP activity is needed (e.g. radiology support).

R7. Coordination between neighbouring LHD and PHN

7.1 Adoption of a stepped model of urgent afterhours will help individuals identify and access the most appropriate level of available service for their needs (e.g. ranging from online symptom checker, virtual GP consultation, afterhours GP clinic or home visit, hospital ED). This includes mechanisms for triaging patients to the most appropriate afterhours options.
7.2 Ensure afterhours services consistently provide communication back to patients' usual care provider.

Figure 21: High profile evaluations of previous primary care reform

High profile evaluations of previous primary care reform



Source: Abbreviated from the following evaluations:

1. Health Policy Analysis 2020, Evaluation of PHN Afterhours Program, Final report Volume 2 Main report, Commonwealth Department of Health, Canberra.
2. Pearse, J.1 , et al (2022). Health Care Homes trial final evaluation report, Volume 1: Summary report. Health Policy Analysis. Commissioned by the Australian Government Department of Health.

Appendix 4 - Patient Off Stretcher Time and National Emergency Access Target

The Patient Off Stretcher Time (POST) target is that 90% of patients must be transferred from paramedics to ED staff within 30 minutes. The National Emergency Access Target is that 90% of patients must leave the ED within four hours through either: being treated and discharged, treated and admitted to hospital, transferred to another hospital, left without/before completing treatment

The following table indicates each hospital's performance against POST and National Emergency Access Target (NEAT) from April 2021 to March 2022. The percentages reflect the proportion of patients that met POST and NEAT targets, with colour coding of green meeting target and red below target.

Table 42: POST and NEAT performance of New South Wales Hospitals, 2021-2022

PHN	Hospital	Patient Off Stretcher Time (POST)	National Emergency Access Target (NEAT)
Central and Eastern Sydney	Canterbury Hospital	91.3%	71.3%
	Concord Repatriation General Hospital	83.9%	59.8%
	Prince of Wales Hospital	76.6%	67.8%
	Royal Prince Alfred Hospital	78.8%	60.1%
	St George Hospital	78.5%	58.8%
	St Vincent's Hospital Sydney	79.8%	56.5%
	Sutherland Hospital	80.9%	57.0%
	Sydney Children's Hospital	96.8%	71.6%
	Sydney Hospital and Sydney Eye Hospital	94.2%	80.0%
Hunter New England & Central Coast	Armidale Hospital	86.9%	73.3%
	Belmont Hospital	72.7%	57.3%
	Calvary Mater Newcastle	68.1%	58.4%
	Cessnock Hospital	92.2%	78.5%
	Gosford Hospital	70.3%	48.2%
	Gunnedah Hospital	99.9%	85.9%
	Inverell Hospital	99.2%	78.9%
	John Hunter Hospital	84.8%	51.7%
	Kurri Kurri Hospital	N/A	95.5%
	Maitland Hospital	89.2%	49.3%
	Manning Hospital	85.7%h	61.2%
	Moree Hospital	97.1%	84.3%
	Muswellbrook Hospital	99.8%	82.5%
	Narrabri Hospital	99.8%	82.2%
	Singleton Hospital	99.7%	88.9%
	Tamworth Hospital	72.9%	56.4%
	Wyong Hospital	57.9%	54.4%
Murrumbidgee	Deniliquin Health Service	97.0%	85.8%
	Griffith Base Hospital	95.8%	74.4%
	Wagga Wagga Base Hospital	84.8%	58.0%
Nepean Blue Mountains	Blue Mountains District Anzac Memorial Hospital	91.6%	69.0%
	Hawkesbury District Health Service	91.7%	61.9%
	Lithgow Hospital	94.9%	79.3%

	Nepean Hospital	74.7%	44.9%
North Coast	Ballina District Hospital	85.5%	76.6%
	Byron Central Hospital	95.6%	81.4%
	Casino & District Memorial Hospital	90.4%	83.8%
	Coffs Harbour Health Campus	80.4%	62.2%
	Grafton Base Hospital	87.8%	70.9%
	Kempsey District Hospital	91.7%	80.4%
	Lismore Base Hospital	68.7%	56.9%
	Macksville District Hospital	91.3%	75.8%
	Maclean District Hospital	88.4%	88.7%
	Murwillumbah District Hospital	95.7%	84.8%
	Port Macquarie Base Hospital	82.7%	73.3%
	The Tweed Hospital	82.9%	68.6%
Northern Sydney	Hornsby Ku-ring-gai Hospital	91.3%	74.8%
	Northern Beaches hospital	98.3%	81.6%
	Royal North Shore Hospital	81.9%	52.3%
	Ryde Hospital	93.9%	72.3%
South Eastern New South Wales	Batemans Bay District Hospital	94.9%	81.1%
	Cooma Hospital and Health Service	97.4%	81.4%
	Goulburn Base Hospital	76.0%	65.8%
	Milton Ulladulla Hospital	92.3%	80.4%
	Moruya Hospital	86.3%	71.3%
	Queanbeyan Hospital and Health Service	97.5%	87.5%
	Shellharbour Hospital	90.3%	61.0%
	Shoalhaven District Memorial Hospital	71.9%	58.0%
	South East Regional Hospital	86.5%	65.9%
	Wollongong Hospital	73.9%	48.8%
South Western Sydney	Bankstown-Lidcombe Hospital	82.4%	65.3%
	Bowral and District Hospital	94.8%	75.7%
	Campbelltown Hospital	83.5%	49.8%
	Fairfield Hospital	89.5%	70.8%
	Liverpool Hospital	77.6%	46.9%
Western New South Wales	Bathurst Health service	80.8%	72.9%
	Broken Hill Health Service	92.6%	79.5%
	Cowra Health Service	85.9%	81.2%
	Dubbo Hospital	80.3%	72.1%
	Lachlan Health Service-Forbes	96.8%	87.7%
	Mudgee Health Service	94.7%	78.2%
	Orange Health Service	90.1%	67.4%
Western Sydney	Auburn Hospital	87.9%	73.1%
	Blacktown Hospital	78.4%	48.7%
	Mount Druitt Hospital	87.7%	64.4%
	The Children's Hospital at Westmead	93.3%	68.3%
	Westmead Hospital	60.5%	42.7%

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Glossary

PHN	Individual PHNs are responsible for identifying and addressing the primary health needs in their region through strategic planning, commissioning services, supporting general practices and other health care providers, and supporting the integration of local health care services.
Afterhours ED	Afterhours ED presentations include Sundays, public holidays, weekdays 8pm-8am and Saturdays before 8am and after 1pm.
Emergency department (ED)	A hospital facility that provides triage, assessment, care or treatment for non-admitted patients suffering from a medical condition or injury.
Formal public hospital emergency department (ED)	Formal EDs have: a purposely designed and equipped area with designated assessment, treatment and resuscitation areas the ability to provide resuscitation, stabilisation, and initial management of all emergencies availability of medical staff in the hospital 24 hours a day designated ED nursing staff 24 hours a day, 7 days a week, and a designated ED nursing unit manager.
Index of Relative Socioeconomic Disadvantage	One of the set of Socio-Economic Indexes for Areas for ranking the average socioeconomic conditions of the population in an area. It summarises attributes of the population such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.
ED low urgency care	ED presentations for lower urgency care are defined as presentations at formal public hospital EDs where the patient: had an emergency presentation type of visit, had a triage category of 4 or 5, did not arrive by ambulance, or police or correctional vehicle, and was not admitted to the hospital, not referred to another hospital, or did not die.
Presentation	When a patient arrives at an emergency department for treatment. As a person may visit an emergency department in a hospital more than once in a year, the number of presentations is not the same as the number of people seen by the department.
Remoteness area	A classification of the remoteness of a location using the Australian Statistical Geography Standard Remoteness Structure (2016). The Australian Statistical Geography Standard-Remoteness Area is a geographical classification that defines locations in terms of remoteness, that is, the physical distance of a location from the nearest urban centre.
Time of presentation	Time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first. METeOR id: 684603.
Triage category	A category used in the emergency departments of hospitals to indicate the urgency of the patient's need for medical and nursing care. Patients are triaged into 1 of 5 categories on the Australasian Triage Scale. The triage category is allocated by an experienced registered nurse or medical practitioner. METeOR id: 684872. Resuscitation (triage category 1): the most urgent category. It is for conditions that are immediately life threatening such as heart attack, severe burns or injuries resulting from a motor vehicle accident. Patients in this category should be seen immediately (within seconds) of presenting to the emergency department. Emergency (triage category 2): conditions that could be life-threatening and require prompt attention such as chest pain or possible stroke. Patients in this category should be seen within 10 minutes of presenting to the emergency department. Urgent (triage category 3): serious but stable conditions, such as wounds or abdominal pain. Patients in this category should be seen within 30 minutes of presenting to the emergency department. Semi-urgent (triage category 4): conditions including broken arms or legs. Patients in this category should be seen within 60 minutes of presenting to the emergency department. Non-urgent (triage category 5): the least urgent category. It is for problems or illnesses such as cough or cold. Patients in this category should be seen within 120 minutes of presenting to the emergency department.
Type of visit	The reason the patient presents to an emergency department
Urgent afterhours GP care	Defined as: 1. Social afterhours (prior to 1 March 2018, items 597 and 598; from 1 March 2018, items 585, 588, 591 and 594): Monday to Friday: 7 am – 8 am and 6 pm – 11 pm, Saturday: 7 am – 8 am and 12 noon – 11 pm, Sunday/ public holiday: 7 am – 11 pm; 2. Unsociable hours (items 599 and 600): Monday to Friday: 11 pm – 7 am, Saturday: 11 pm – 7 am, Sunday/and or public holiday 11 pm – 7 am

Non urgent afterhours GP care	Afterhours attendances provided by a medical practitioner have been introduced: 1. At consulting rooms (items 733, 737, 741 and 745): Monday to Friday: Before 8 am or after 8 pm, Saturday: Before 8 am or after 1 pm, Sunday/and or public holiday: All day. 2. At a place other than consulting rooms (items 761, 763, 766, 769, 772, 776, 788 and 789), Monday to Friday: Before 8 am or after 6 pm, Saturday: Before 8 am or after 12 pm, Sunday/and or public holiday: All day. Includes home visits and visits to residential aged care facilities.