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Ian Thompson
Deputy Director-General
Canberra Hospital and Health Services
Health Directorate
Email: ian.thompson@act.gov.au

Dear Mr Thompson,

Re: HCCA Feedback on the proposed Overcapacity Protocol at the Canberra Hospital

The Health Care Consumers' Association (HCCA) welcomes the opportunity to provide written feedback for the review of the proposed Overcapacity Protocol at the Canberra Hospital. We are generally supportive of this approach to peak times and recognise the importance of developing a risk management framework to ensure those sickest and most at risk receive adequate health care.

In preparing for this submission we consulted with our membership and also held a consumer consultation including the consumer consultation which you attended.

The need for this strategy is an opportunity to reflect on what is driving the significant growth in yearly presentations to the emergency department at Canberra Hospital. ACT Health has shown that this growth has been not linked to population growth and is more likely a result of consumer behaviour, for example choosing to attend Canberra Hospital rather than Calvary.

HCCA believes that much of this growth comes from years of under service in primary health care for the ACT community both within and after-hours which has led consumers top the ED for care. We acknowledge the rapid expansion of community services such as the new community health services and the nurse led walk-in centres as well as privately led bulk billing after-hours GP services. These new services will continue to provide choices for consumers to receive the right care at the right time in the right place, however the community requires a commitment from ACT Health and service providers to provide education and training and a broader engagement strategy that ensures it reaches marginalised communities and groups within the ACT.

There are several barriers that prevent access and use of primary health care services, particularly after-hours in the ACT. The key barriers identified by our membership and the ACT community are;

1. lack of awareness of services available,

2. out-of-pocket cost

3. lack of use and access to interpreter services.

Lack of awareness and understanding of primary health care and after-hour options: Knowing your options

Many consumers do not have an understanding of the scope and nature of after-hours services, particularly in the Culturally and Linguistically Diverse (CALD) community.

> *"I don't know about the after-hours health care options and don't know about the next door Tuggeranong Community Health Centre. I wish I had this information when I just arrived here". – HCCA information session on After-Hours options*

HCCA partnered with ACT Medicare Local running community information sessions on after-hours options. After these sessions many stated that they felt better informed about where to go if they get sick after-hours.

> *"My son is asthmatic and I'm are very glad to be better informed about our health care options at night, which is usually when my son gets sicker" – HCCA information session on After-Hours options*

In this training HCCA uses infographics and diagrams showing where to go depending on their level of illness or injury[1]. Translating these infographics into other languages and provide phone numbers when applicable would be a useful tool for many consumers.

These issues are covered in more detail in the report we completed for the ACT Medicare Local earlier this year to support their Comprehensive Needs Assessment. The report, *Primary Health Care in the ACT: Consumer Experiences*[2], is available online.

Out-of-Pocket Costs

After-hours GP costs in the ACT are prohibitive, causing many consumers to opt for ill health, poverty, or use an already over capacity emergency department for primary

[1] Health Care Consumers' Association of the ACT Inc, (2014) After-Hours Presentation ACT Medicare Local Omnibus Project. Accessed on 24/10/14: http://www.hcca.org.au/component/rsfiles/download?path=HCCA%20Publications%202014/After%20Hours%20Presentation%20FINAL%20DRAFT.compressed.pdf

[2] Health Care Consumers' Association of the ACT Inc, (2014) Primary Health Care in the ACT: Consumer Experiences. Accessed on 28/10/14: http://www.actml.com.au/Uploads/Documents/CNA%202014/FINAL%20DRAFT%20HCCA%20PHC%20Consumer%20Experience%20Report%20to%20ACTML%20-%2023%20January%202014.pdf

health concerns. Lack of after-hours options when seeing a GP was also an issue, with many people reporting that locum services provided by CALMS cost charge around $100 before the Medicare rebate, leaving a large financial burden for the individual consumer. We note that the National Home Doctor Service is bulk-billed, providing some help with this, however due to the huge demand for these free services the providers are finding hard to meet time targets and see all those who contact them.

In 2009 and 2013 HCCA conducted a survey on the consumer experience of general practice within the ACT region. In both years more than 600 people completed the survey. This represents a useful snapshot of consumer experience. In four years out-of-pocket costs to the consumer for GP appointments has risen by 25% in the ACT.

> *"If I get sick after 5pm, or on weekend in the afternoon, I really have to think, do I want to choose between spending my pension money on food or seeing a GP I don't know or trust? Then I think 'Am I sick enough to go to ED?'" – Consumer from HCCA out-of-pocket cost consultation, 2014.*

If people do not have the money to access after-hours services they go to the Emergency Department at the public hospitals. In Canberra many consumers use nurse led Walk-in Centres, however many consumers do not know their scope or hours of operation, highlighting the need to continue to promote these services across the community and particularly consider targeted campaigns for people living in disadvantage and / or marginalised communities.

We would like to see more community information sessions about primary health care services and after-hours options. It would also be useful to publish more brochures in community languages about primary health care and after-hours services as well as further promotion of Find a Health Service

Consumers also want a walk-in clinic option to see a GP, without having to make an appointment so people can be seen quickly.

Interpreting services

> *"There are new migrants arriving all the time in Canberra and there is no one providing this sort of information to new arrivals". - Father from Multicultural Play Group HCCA information session on After-Hours options*

Many CALD groups HCCA provided information sessions to state that navigating the health care system in Canberra is often daunting and that it isn't made clear what services are available and when to use them. Most people attending the sessions said they prefer to use interpreters when they visit their doctors. One mother said, that in one occasion it was the doctor who got the interpreter because he wanted to make sure she understood everything that was happening with her health. Others mentioned that they usually don't ask for an interpreter because their partners speak for them.

There is also a level of confusion in some groups about payment for interpreter services which acts as a disincentive to accessing care.

Healthdirect nurse call centre and GP hotline.

While Healthdirect is a useful service to complement existing primary care services it is not without limitations.

Many consumers express frustration at the triage process which often feels like a checklist and can often be quite alarmist.

> *"[healthdirect is] sometimes useful although the nurses seemed to play it safe in recommending further medical attention, which was a little alarmist." (Playgroups ACT survey respondent)"*

Whilst most consumers are aware of this service many state that they feel mislead as they believe they will be speaking to a doctor rather than a nurse -led triage system. The name GP- hotline for many consumers seems like false advertisement.

CALD consumers often said when they attempt to use healthdirect they try and to use TIS and are kept waiting for half-an-hour before an interpreter is available.

HCCA would like more promotion of healthdirect and free phone calls from mobile phones.

General Comments

HCCA is supportive of the approach ACT Health and the Canberra Hospital are taking to address the growing safety concerns for patients due to the hospital running at overcapacity. We appreciate that this protocol has been developed within a risk management framework.

How does this protocol link to other initiatives currently in place?

We understand that the overcapacity protocol is one of a range of approaches hospital management are taking to improve the flow of patients through the hospital. We think there is value in providing information about these approaches and how they are contributing to improving patient flow and ensuring that people receive the care they need in the most appropriate place. We are particularly interested to know, how does this protocol work with Canberra Hospital Winter Strategy and Project Venturi?

HCCA would also like to know why this option for dealing with overcapacity was chosen over others, many of our members asked; did ACT Health consider the use of recliner chairs rather than a bed? Was enhancing the Discharge Lounge considered as an option?

Communication about the protocol- what does it mean for consumers, families and carers?

Communication with the patients and families is incredible important. Community information is also important. We suggest the development of fact sheets and Frequently Asked Questions and make this available on the ACT Health website in English and common community languages, promote via social media, promote through stakeholders, and provide in hard copies around the hospital campus and community health centres.

Language used in communicating the key messages to the patients and their families and visitors need to be clear and address their information needs. People affected by the protocol will be experiencing heightened level of anxiety about personal and nursing care and they need assurance that they will be cared for. Key messages need to include that care provided is based on clinical need and standard observations, meals, medication, a call bell will be provided and a clear definition of non-traditional space.

There also needs to be acknowledgement that the area may not be as restful as if patients were in a traditional hospital room and there may be increased noise. This protocol should include reference to the recent research conducted at the Canberra Hospital that found nurses were a key source of noise that disrupted sleep of patients, which can cause significant health issues and delay recovery. It is important to address this within the protocol or any standard operating procedures that follows.

Carers and family also play an important role in recovery we would like the protocol answer what space is available for visitors?

At no point in the protocol is it explained what the minimum requirements are for a space to be designated an 'Overcapacity Bed Space' or in what way(s) this differs from a normal patient bed space, this could be to be clarified.

How will I be assured that this protocol is safe, quality care?

The protocol must clearly outline the maximum time someone will spend in this not traditional ward space areas. HCCA would also like the protocol to address what happens if the patient moved to the non-traditional ward space deteriorates after being transferred there? How would such a scenario be managed?

Whilst HCCA supports the use of a risk management protocol such as this, we want an undertaking that patient outcomes will be measured to determine if there are adverse impacts on the quality and safety. This reporting needs to be made public to ensure transparency, accountability and a commitment that the protocol can be iterative and respond to any needs or safety concerns that make be picked up during implementation.

On page four, the protocol states; '*The patient identified to move to the OCBS will be informed of the move by the ward's CNC or Team Leader.'* Many of our members highlighted this as an extremely important issue that need to be handled carefully, including informing any family members and carers. Some specific questions are;

how long before the actual transfer will the patient, family and carers be informed? Will the patient, family or carers have any capacity to object?

The protocol states: *'If no patient can be identified for discharge, the safest of the existing patients must be moved.'* What if it is not clinically safe to move any of the patients on the ward to an overcapacity area, or the "lowest risk patient" still involves an unacceptable level of clinical risk? This is a possibility and needs to be included in a risk management protocol such as this on.

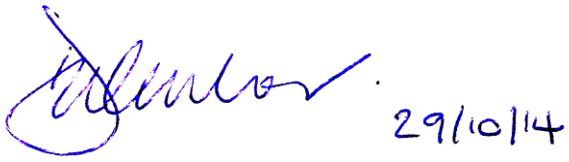
Several members highlighted the increased risk of moving patients to areas not best suited to caring for their clinical need or 'outlier' patients, many asked; will the medical and nursing staff on the ward have the relevant skills and protocols to manage the newly arrived ED patient appropriately and how will risks to clinical safety of the newly arrived patient from the ED be addressed in these circumstances?

The questions put forward by the participants of the consumer consultation (13 October 2014) are attached.

We would like to work with ACT Health in refining the key messages around this protocol and provide comment on the communication strategy.

We are happy to discuss our submission further.

Yours sincerely,



Darlene Cox
Executive Director

Questions and Feedback

1. How will this protocol be affected by the Health Infrastructure Project and Changes to bed space in Building 3/2?
2. We need a FAQ page to address our concerns! Maybe even an interactive infographic highlighting what this all means!
3. What training will the staff receive? Just because a patient is in front of the nurses station doesn't mean I receive good or safe care, I have stood there before and be completely ignored! Staff need to be trained.
4. How will the nursing profile change within a team nursing scenario in their approach to patients?
5. Will this effect patients who have private health insurance or private patients as well as public patients? Does this create two standards of patient care?
6. Can you provide Snack Packs for people with specific dietary requirements?
7. Will this mean that discharge planning is rushed, is there appropriate care for people at home, how will this be organised?
8. Can these patients still have access to allied health workers such as social workers what if they need privacy?
9. How will you ensure you are meeting the National Accreditation Standards in this setting? For instance how will you address checks for pressure injuries etc?
10. How will you make sure that it is not just the older quieter patients that are moved and they know they can speak up if they have any concerns?
11. You can't tell us that 'we want to be kept at home' or 'out of hospital' this might be the most appropriate place for us, it has to be about patient safety! We may not have resources at home.
12. Who will be responsible for ensuring patients are getting help for toileting if necessary, food, water and an alarm button. What about people with specific needs? They need one point of contact to get help from.
13. Do these patients have separate statistics in terms of duration of stay?
14. Telephone handovers can compromise patient care, will the protocol mandate face-to-face health professional handovers as soon as possible?
15. If the decision is being made at 3pm according to the document there is no way they will be discharged at 5pm this decision must be made earlier! After morning rounds if you are going to discharge and not leave people there overnight.
16. Isn't the real problem on weekends and after-hours when the protocol is not in place?
17. Why have certain wards been chosen and what sets them apart from others?
18. What strategies will be put in place if the co-payment is put through and more consumers start presenting to ED?
19. How long did it take for this strategy to become successful in Liverpool Hospital and elsewhere?
20. Will this be a trail? Will it be evaluated?
21. Who else is providing input or comment on this? Health Practitioners?