**Influenza**

**After Hours and Emergency care**

20.2.10

**Aims**

1. Reduce infection rates
2. Provide timely and appropriate advice and care
3. Manage health resource to minimise impact on other patients

**Reduce infection rates**

* Immunisation
	+ Staff
	+ patients
* Infection control
	+ community messages
	+ within practices

**Timely and appropriate advice**

* 0800
* Consistent advice from practices –central communication

**Timely and appropriate care**

* 8-5 weekdays
	+ GP teams mange own workload,
	+ Option of 0800 HML to triage calls?
	+ Overload management – inappropriate to use ambulance/ED without adequate triage, 24HS flex capability if practice load too great?, central pool of nursing support for practices?, acute demand home visits?
* After hours
	+ 24HS/Riccarton/Moorhouse capacity and ability to anticipate demand and flex to meet demand
	+ ED capacity/overload
	+ 0800 HML triage
	+ Cost to patients

**Managing health resource**

**Issues and suggestions**

1. Daytime demand greater than practices can manage
* Usual default is to ambulance/ED or 24HS
* Consider
	+ Reduction of routine workload
	+ Pharmacy support to provide repeat routine scripts
	+ increased acute demand capacity for support (home visits?)
	+ extra staffing at 24HS during day
	+ Pool of extra nursing staff available for practices
1. Capacity for extended support/care of patients
* Many significantly unwell people were managed at CBAC (IV fluids, etc)and discharged, reducing load on ED
* Capacity to do this in individual practices is varied and limited
* Obs unit has limited capacity – option of increasing obs unit capacity/staffing, ?separate site for infection control
* Acute demand support for IV fluids in practices?
* Acute demand support for subcut fluids in homes?
* Acute demand support for follow-up visits for patients after intensive management episode?
* Ability to increase acute demand capacity for all of this?
1. After hours demand
* Ability to predict demand and staff accordingly - cost implications of overstaffing cf care implications of understaffing
* Flexibility of staffing levels
* Space and infection control considerations - ?need for portacom or similar at 24HS
* Capacity for extended support – see above
1. Cost as a factor in determining where/when patients attend
* Free and closely located service last year increased ability of ED to redirect patients
* Cost is one barrier to GP and 24HS attendance for high needs patients
* Reducing cost of GP and after hours services to these patients could increase likelihood of appropriate care, and reduce load on ED
* Relative cost/benefits and difficulties of determining eligibility for reduced cost for all flu/resp illness/febrile patients vs high needs patients only
* See suggested models below
1. ED issues

**Cost suggestions**

1. Fund increase in acute demand/obs unit capacity for a specified period of time
2. Subsidise practices (directly or through acute demand claim) for extended care for flu patients when required
3. Work with 24HS to fairly underwrite some of risk associated with planned increased staffing
4. Consider payment to practices to offset similar planned increases in staffing and changes to practice management to appropriately manage flu patients this season, eg funding for additional nurse triage staff in practices
5. Additional funding for nursing hours to identify and encourage flu vaccination for high risk patients
6. Patient subsidies

Note:

All subsidies would need to be advertised widely to reduce attendances at ED by this means

Subsidising flu consults would in fact mean subsidising all consults where the patient actually has flu, and where the patient/triage person thinks they might have flu, as the patient would need to know at the time of booking what the cost will be, not after.

* 1. Subsidise all flu related visits
	2. Subsidise flu-related visits for a specific population, eg
		1. all “high risk” patients
		2. Maori/Pacific/NZDep9&10 – difficulty in general practice and ED in accurately determining who falls into this group
		3. Children under 5 – could be seen as unfairly penalising those practices who already offer free visits to this group (mainly high needs)
	3. Subsidise flu-related visits in particular settings eg
		1. After hours settings – all practices after 6pm, or only nominated after hours facilities? Potential for perverse incentives
	4. Provide vouchers for subsidised consults eg from ED (risk of perverse incentive to attend and get voucher), from practices where follow-up consult will be needed at weekend
	5. Provide a pool of subsidy money for practices to access when they consider needed, similar to SIA fund, could also provide after hours care vouchers out of pool.