**Submission No 54**

# THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

**Organisation:** Bulgarr Ngaru Medical Aboriginal Corporation

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**Submission to the Select Committee on Remote, Rural and Regional Health inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.**

Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC) is an Aboriginal Community Controlled Health Service headquartered in Grafton, NSW. It provides comprehensive primary health care services for Aboriginal people over a wide area from Grafton and surrounds through to Casino and its environs. It also manages the Bugalwena General Practice in Tweed Heads. It runs 5 day a week health services from premises in Grafton, South Grafton, Casino and Tweed Heads, as well as outreach clinics in another 5 smaller centres. It is run by a Board of Directors of Aboriginal people representing the communities it services.

It was established in 1991 and currently employs 123 staff. It provides a comprehensive range of health care and related services, including medical and dental care, mental health services, tobacco, alcohol and other drug programs, nutrition support and health promotion programs. In doing so it employs and manages staff across a broad range of professional disciplines as well as administrative and management personnel.?

In addition to managing its core funding and its service delivery responsibilities, it has been successful in gaining and managing many funding grants to augment its core funding, develop new programs or for special projects.

The service began originally in Grafton. It was subsequently able to assume the management of the Aboriginal Medical Services that existed in Casino and Tweed Heads. It was able to do so because of its success in delivering primary health care eservices in the Grafton area, its ability to work with and gain the trust of the Aboriginal community in the other regions and the confidence that state and federal funding agencies had in its ability to deliver health services across a broader region.

**Opening statement**

Much has been made of the need to prevent hospitalisation and attendance at emergency departments in the public hospital system, and to address the potential crisis in rural health care. We believe this can only

be done by strengthening the non government primary health care sector. This is where the majority of health care is delivered, where enhancements to capacity are likely to have the greatest direct benefit and where the opportunities for preventive health care are greatest. And yet, the very great majority of the $833m earmarked for rural and regional health care is to go into the NSW Health system. We believe far more investment is required in the PHC sector both in material capacity but also in quality of care and accountability measures. Some might say that primary health care is a Commonwealth responsibility. But the people of NSW and the NSW Health department would directly benefit from a strengthened PHC system.

On the issue of the culture of the Local Health District (LHD) and how it relates to the primary health care and particularly the AMS sector.
There is much in health department plans and vision statements about community centred and collaborative, partnership approaches. In Northern NSW there is a formal partnership agreement between the 3 AMSs, the PHN and the LHD. But in practice, our dealings with LHD management are a frequent source of disappointment and frustration. There seems a culture of arrogance, lack of listening, a propensity to make unilateral decisions that can have a significant impact on primary health care services and their clients as well as a seeming failure to understand that people live in the community not the hospital and that the PHC sector is where the great majority of health care actually occurs.

In a written statement to the Committee we have provided some detail on initiatives that the 3 Northern NSW Aboriginal Medical Services (AMSs) working collaboratively have undertaken in our region to enhance our clinical services, highlight important public health issues, work towards demonstrable improvements in clinical care that should improve overall care in the region and reduce demand on NSW health services and, by creating a more supportive environment, increase our ability to recruit and retain medical staff.

<u>Regional collaboration between Northern NSW AMSs</u>

Over the past 18 months BNMAC has provided leadership and resources to support an active collaboration between the three AMSs in the region: BNMAC, Bullinah Aboriginal Health Service in Ballina, and Rekindling the Spirit Health Service in Lismore. This collaboration has involved both management and clinicians in a range of measures within these health services and relating to the LHD. We believe that these measures demonstrate the ways in which the AMSs have addressed improving clinical care, their own workplace culture and workforce development as well as illustrating some of the instances of the source of dissatisfaction with the LHD.

An essential element of much of this activity model is that it must directly involve working clinicians and be resourced. If a health service is to improve an area of its clinical service it needs its clinicians involved in planning, research, development of ideas via consultation, implementation and evaluation. This is work that does not involve seeing patients and billing Medicare. Clinicians need dedicated, paid time to perform this work and the health service must resource it from sources other than Medicare.

The model the AMSs in northern NSW have adopted to implement this work involves:

- paid time for each individual GP to carry out clinical quality improvement activities,
- lead GP clinicians in each clinic to coordinate and support health service improvement activities and GP education at the clinic level, and
- a regional coordinator position to work across all three AMSs to provide coordination as well as strategic, public health and clinical technical support.

This model, and the activities we have undertaken, are pertinent to the funding, workforce issues and workplace culture foci of the parliamentary inquiry.

Regional AMS clinician conferences

In November 2022, May 2023 and November 2023, regional AMS conferences were held on Saturdays in Ballina. The aim of these conferences is to provide an opportunity for GPs and other clinical staff for networking, clinical education, and, more importantly, to raise and address public health and health service delivery issues across the region. All conferences were attended by between 30 and 35 people and feedback has been extremely positive. Conferences are organised by a committee of GP representatives from each clinic who are allocated paid work hours by their AMS to organise the overall conference and individual sessions. The regional coordinator plays a major role in organisation. BNMAC provides the overall funding and logistic support for the conferences.

The focus on health service issues in these conferences is very important. They are attended by health service senior managers and clinic managers as well as clinicians. This allows for a more inclusive and engaged discussion of health service issues and improves the potential for finding, agreeing and actioning ways forward. As a direct result there have been major new health service initiatives implemented across all services and an enhancement of the cooperation and coordination between the services and adoption of common approaches to common issues. The conferences provide a mechanism by which clinicians can not only gain education, but also directly contribute to health service policy, initiatives and overall direction. Specific examples more fully described below include the QI / CPD program and the Opiate Replacement Therapy initiative.

QI / CPD program

This concept was canvassed in the lead up to the first clinicians conference, discussed and agreed to by participants and has been implemented since.

In this program all GPs are given quarantined work time (usually 2 hrs per month) during normal hours to do clinical quality improvement work. This consists of initial education and discussion, case note audits (if necessary initiating follow up for individual patients to ensure they are receiving the required standard of care), collation and feedback of results and discussion of implications and areas for improvement. Quantifiable indicators are generated to be re-measured in future to assess whether there has been a practice wide improvement.

Some of this work is coordinated at local clinic level by the lead clinicians. Much of the technical work, for example extracting data, generating patient lists and developing the conceptual and practical framework for the audit is done by the regional coordinator and shared across all services.

A very important element of this program is its direct focus by the clinicians themselves on actual clinical management and outcomes with a direct link to the care of individual patients.

This is in contrast to, for example, the AIHW national Key Performance Indicators, which largely reflect activities rather than clinical outcomes. The few that do reflect clinical outcomes, for example birthweight result, HbA1C result, and renal function result are population level measures which reflect the full range of environmental, behavioural and clinical management influences and are of limited use at clinic level in ensuring people with diabetes, chronic kidney disease or hypertension are receiving appropriate medication and monitoring. It also contrasts with other CQI programs that are generally conducted by outsiders, either without or with very little involvement of the clinicians providing the actual care.

Our program focusses on how GPs are assessing and managing individual patients with reference to an agreed standard of care with education, technical support, performance measures and accountability built into a system, which also allows for immediate improvement for the care of individuals.

In addition to providing the health service with a QI program directly relating to improving clinical care, the system provides a mechanism for GPs to gain the necessary Continuing Professional Development hours in the "performance review" and "outcome measurement" categories now required by the Australian Health Practitioners Regulatory Authority.

Opiate Replacement Therapy (methadone and buprenorphine programs) initiative

As a result of a session in an AMS conference for clinicians concerning access to services for clients with Alcohol and Other Drug (AOD) problems, it was agreed that the AMSs would work towards providing improved access to Opiate Replacement Therapy (ORT) for Aboriginal people. Until this time there were only a handful of people receiving this therapy via an AMS in the region, but large numbers of Aboriginal people within the NSW Health program. A weekend training day was organised with the support of the NSW Health AOD program and AMS GPs and nurses were paid by their AMSs to attend. Over 20 GPs attended as well as several nurses. Several GPs have attended the LHD specialist clinics for follow up clinical training time. An MOU has been signed between the AMSs and the LHD to regulate and oversee a process whereby stable Aboriginal clients of the LHD system can be transferred to the care of the AMSs and back again if necessary. The process of transferring patients is beginning now, albeit at a very slow pace.

Acute Rheumatic Fever and Rheumatic Heart Disease in Northern NSW

AMS clinicians in Casino became concerned about the number of cases of Acute Rheumatic Fever (ARF) in the area and also by the poor quality of care they were receiving within the hospital system. ARF is now relatively rare in the general population, but much more common in Aboriginal people. Generally speaking most clinicians have little to no experience or awareness of it.

As a result, the three AMSs agreed to do a comprehensive audit of medical records across all their clinics to explore the matter. It revealed a much greater prevalence of Rheumatic Heart Disease (RHD) in the region than was appreciated and a significant need for improvement at both AMS and hospital level in the management of people with ARF/RHD. Within the AMSs a major education process was put in place to improve ARF/RHD management and prevention within the AMSs, new systems involving local cardiologists developed to ensure timely access to echocardiograms, and active follow up of all patients with possible RHD was instituted to clarify their situation and ensure they are receiving appropriate care.

The AMSs also approached clinicians within Lismore Base Hospital in order to raised awareness and improve management. A working group established between AMS and hospital clinicians developed an agreed standard of care and referral pathway. AMS clinicians began to notice an improvement in the care of these clients and communication about them from the hospital. Also as a result of the AMS work, a significant number of new and older cases of ARF and RHD were able to be notified to NSW Health to give disease control authorities a better appreciation of the situation in northern NSW. This was received very positively by the disease control authorities.

The LHD employed a nurse part time dedicated to developing an ARF/RHD clinician education strategy across the LHD footprint and enhancing coordination between the LHD and the AMSs. However, at this point the LHD gave the Aboriginal Health Unit the lead on this issue, which disbanded the successful working group. The standard of care and referral pathway which had been agreed to was discarded. The working relationship with the AMSs has significantly deteriorated. It is unclear where the LHD wide education strategy is up to.

The Aboriginal Maternity and Infant Health Service (AMIHS) issue.

The AMIHS program provides important antenatal health care for Aboriginal women in our region and is highly valued and depended upon by all 3 AMSs. The AMIHS teams of midwives and Aboriginal Health Workers provide a shared care model of care with the AMS teams, but, in effect, provide the majority of day to day antenatal and postnatal care for pregnant women. The AMS and AMIHS teams generally enjoy a productive and cooperative working relationship.

Recently however two events took place which caused considerable tension between two of the AMSs (BNMAC and BAHS) and the LHD. The midwife providing the services to BAHS was seconded to another position and was not replaced over a 7 week period. There was no notice given, no discussion with BAHS about this disruption to the service and no discussion about interim arrangements or how long it would take to resume the service.

The BNMAC service in the Casino clinic always has high numbers of antenatal clients many of whom are high risk. Because of this, BNMAC funds the AMIHS midwife for that area to provide an extra day per week in addition to the 2 days a week she is funded by the LHD. The Casino team and the AMIHS midwife and AHW enjoy a very good working relationship. Recently, there was a significant increase in antenatal clients in Casino, and with the knowledge of the Casino AMS team, the AMIHS nurse made a request for increased hours to her NSW Health manager. She was initially instructed by her senior manager to reduce her case load by triaging clients and handing some back to the AMS GPs to manage. Again, there was no discussion about this proposed reduction in services with the Casino AMS.

The CEOs of both BNMAC and BAHS considered these decisions and the way they were made by LHD management to be unacceptable, in terms of a unilateral service reduction, and discourteous to what are supposed to be partner organisations. These issues were raised by the CEOs of the AMSs directly with senior management of the LHD and via the regional partnership forum. As a result, the Casino AMS is to get increased midwifery support. It is unclear whether the AMS representations had an impact on the time taken to resume the BAHS service.

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**Supplementary notes following evidence given on 27 November 2023 to the Select Committee on Remote, Rural and Regional Health inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.**

# A regional, collaborative approach by Aboriginal Medical Services in Northern NSW to improving health service delivery for Aboriginal people

**Summary**

Over the past 18 months, the Northern NSW Aboriginal Medical Services - Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC), Bullinah Aboriginal Health Service (BAHS), and Rekindling The Spirit (RTS) – have been engaged in a regional, cooperative approach to enhance their health service delivery for Aboriginal people in the region. BNMAC believes this approach is already leading to appreciable benefits with the potential to increase more in a number of domains;

- Improving quality of clinical care in a measurable fashion with direct benefits for clients and potentially reduced demand for hospital care.
- Making fuller and better use of the expertise of AMS clinicians.
- Enhancing and broadening the work experience and support for AMS clinicians and so improving the ability of the AMS to attract and retain clinical staff.
- Providing public health leadership to the region.
- Providing greater partnership assistance to NSW health in matters relating to the health and health care of Aboriginal people.

BNMAC further believes the model could be more broadly emulated and supported by NSW Health and doing so would address a number of the challenges in remote, rural and regional health settings that the parliamentary committee is currently considering. Given the role of the Commonwealth in primary health care, the model could be considered by the Bilateral Regional Health Forum.

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The model the AMSs in northern NSW have adopted to implement this work involves:

- paid time for each individual GP to carry out clinical quality improvement activities,
- lead GP clinicians in each clinic with dedicated time to coordinate and support health service improvement activities and GP education at the clinic level, and
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The focus on health service issues in these conferences is very important. They are attended by health service senior managers and clinic managers as well as clinicians. This allows for a more inclusive and engaged discussion of health service issues and improves the potential for finding, agreeing and actioning ways forward. As a direct result there have been major new health service initiatives implemented across all services and an enhancement of the cooperation and coordination between the services and adoption of common approaches to common issues. The conferences provide a mechanism by which clinicians can not only gain education, but also directly contribute to health service policy, initiatives and overall direction both of which enhance their technical capacity and work satisfaction. Specific examples more fully described below include the Quality Improvement / Continuing Professional Development (QI / CPD) program and the Opiate Replacement Therapy (ORT) initiative.

Quality Improvement / Continuing Professional Development program

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population, but much more common in Aboriginal people. Generally speaking most clinicians have little to no experience or awareness of it.

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**Key concepts and benefits of the regional, collaborative approach**

The program provides the resourcing and technical expertise to allow for a more systematic, informed and coordinated process for the improvement of health service delivery. It provides a mechanism to be more proactive in addressing health issues. This applies within an individual service and across all the services and so reduces the fragmentation of service delivery in the region.

By having a united approach and increased technical ability the capacity for AMS leadership is enhanced in relation to both Government and Non Government agencies regarding public health and health service issues.

It enables GPs to enhance and expand their role and focus within the AMS in a way which builds in commitment. The regional conference concept provides a mechanism for GPs and other clinicians to have greater input into models of care, potentially fostering innovative, community responsive models. This should increase the contribution they make to the health service, increase their accountability and, hopefully, increase their job satisfaction and perception of AMSs as a place to work.

This model requires resourcing and coordination and cooperation across services.

To meet their needs, AMSs cannot rely upon GPs to do meaningful QI or service development activity on their own time. They must give GPs paid time to do this work and some of it at least needs to be done within normal work hours.

The need for a common, coordinated approach by AMSs to public health or health service delivery issues requires coordination, technical expertise and dedicated time resource within the AMSs. A resource to do this can be shared efficiently between services in the form of a regional coordinator. This position and its role needs to be recognised by each of the AMSs. This is enhanced if the coordinator is formally employed

as a doctor by each service with a similar or the same job description in each. The coordinator therefore has accountability to all services, legitimate access to clinical records and is bound by the privacy codes of each service. This allows the coordinator to provide individual support within clinics and work across all clinics to facilitate the regional approach. It also enhances the capacity of the coordinator to represent the three AMSs in their dealings with other organisations and agencies such as the LHD.