Submission
No 55

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

Organisation: Inverell Health Forum

Date Received: 26 April 2024

Submission to: **Select Committee on Remote, Rural and Regional Health**
Parliament of New South Wales

Made by: **Inverell Health Forum**
Inverell NSW 2360
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Update on Progress made in implementing the recommendations made in the Implementation of the Recommendations made by PC2.

Inverell Health Forum:
The Forum is an Inverell community initiative, supported by Inverell Shire Council and chaired by Cr Wendy Wilks, comprised of councillors, general practitioners, medical practice managers, Aboriginal health service providers, representatives of business and industry, and community members that convenes for the purposes of furthering the aims and objectives described below.

Aim:
The purpose of this submission is to share practical recommendations and strategies to improve the quality of healthcare for Inverell and all rural and regional communities, resulting in timely health outcomes similar to those experienced in metropolitan areas.

Objectives:
- Improved health outcomes for Inverell, and rural and regional communities generally, through increased provision of both public (hospital) and private (general practice) medical services at a local level.
- Increased consultation on healthcare policymaking, so that practicing local rural health professionals and their communities have a say in decisions that directly impact them.
- To see members of rural and regional communities obtain primary healthcare equity within a reasonable distance of their residences, in line with metro area norms.

Background: Situation as per our original submission and updated progress following P 3
Inverell Shire is a vibrant community of around 18,000 people, which boasts a strong economy, thriving industry, and a growing population.[1]
The development of a new $60 million hospital completed in 2021 came with the promise of two equipped operating theatres and adequate staffing levels to ensure patient care for Inverell's residents and remove the need for frequent travel to larger centres.

Unfortunately, this outcome has not eventuated, with the level of healthcare declining over many years through the reduction of services at the Inverell hospital, along with an increasing shortage of general practitioners.

The Inverell hospital is often without a doctor on duty, and ambulance resources and skills are wasted on transporting patients to other towns; an estimated 480 non-emergency

patient transports from Inverell occur annually. Transporting a patient to Armidale removes an ambulance from Inverell for a minimum of four hours, and transport to Tamworth involves six hours of ambulance time. The community is at risk due to the lack of available ambulance services during these transports. Patients whose care is deemed non-urgent are expected to arrange their own transport for treatment, causing extra physical and emotional stress, as well as isolation from family and financial hardship. Travelling a three-hour return trip for treatment that should be available locally is an unreasonable expectation.

The critical shortage of general practitioners also means Inverell residents are unable to access basic healthcare services, such as an appointment with a doctor, causing great distress and adversely impacting their quality of life. This also affects the health and wellbeing of the few GPs we have, as they have taken on extra, unsustainable workloads. The very real risk of burnout will further reduce the number of GPs practicing in our community, and makes recruitment of new GPs highly challenging.

Inverell doctors are currently restricted by hospital rating policies on the procedures they are allowed to perform, even when they have the required qualifications and experience. Patients are routinely required to travel by road for three hours or more – often at great physical discomfort and/or real risk to their health (e.g., in late pregnancy and/or in early labour) – when a very capable doctor is available and willing to perform a procedure at the Inverell hospital.

Inverell residents need and deserve more than a referral hospital. The lack of reasonable access to basic healthcare is far more than an inconvenience for communities like Inverell. In reality, for many people it is a life-or-death matter. Because primary healthcare is often not locally available, many residents postpone seeking medical attention, knowing it will in all likelihood mean travel and isolation from family and familiar surrounds. Sadly, in some cases this delay means help comes too late. We have been given to understand that the DOA ("dead on arrival") rate at Inverell hospital is allegedly the highest in the state.

There is also a disconnection between the decision makers and the communities they are intended to serve. Policies based on external considerations and/or preconceived ideas of what rural and regional communities need – with little or no direct consultation – have serious implications for these communities.

Inverell residents conveyed their many concerns to members of the Inverell Shire Council, resulting in Cr Wendy Wilks forming the Inverell Health Forum to identify issues and try to find solutions for the healthcare crisis in our community.

In identifying shortcomings in the healthcare available to Inverell residents, it was seen that many other rural communities face similar issues. This healthcare crisis requires action, not just at a local level, but also through state and federal government intervention.

Updates on the Implementations since October 2023

Recommendation 19 That the rural and regional Local Health Districts: 99 • formalise and remunerate on call arrangements for nurses and midwives across all public health facilities in accordance with industrial awards • engage with the emergency departments in their area to develop agreed plans to address security issues with timeframes and regular progress reporting • increase and formalise professional development opportunities for nurses and midwives, ensuring that rostering accounts for this.

No updated actions

Recommendation 20 That NSW Health, as part of its review of the nursing and midwifery workforce: 100 • develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally and regionally based education, training and professional development to become qualified nurses and midwives • develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career, specialised or are experienced to practice in rural and remote locations • implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations.

No updated actions

Recommendation 26 142 That the NSW Government implement the midwifery continuity of care model throughout rural, regional and remote New South Wales.

No updated actions

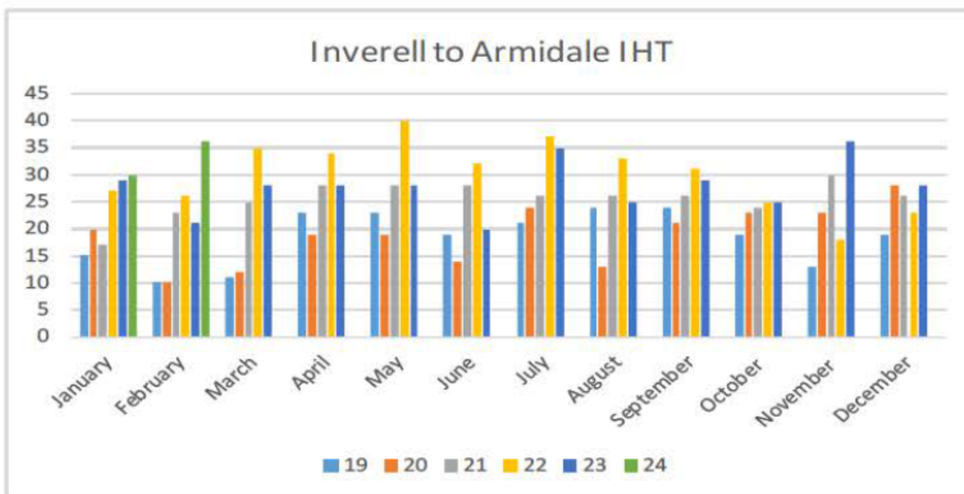
Recommendation 27 142 That the rural and regional Local Health Districts, and those metropolitan Local Health Districts that take in regional areas of the state, review their maternity services in order to develop plans for midwifery, GP Obstetrics, specialist Obstetrics and newborn services.

No Action to improve at Inverell Hospital
No Permanent Anaesthetist provided for Obstetricians to perform routine or emergency Caesarean sections and other related surgeries. In February alone, this resulted in 11 expectant mothers being needlessly transferred away from their homes and families, plus 1 that did require more specialised care.
Locums are provided when they are available to be sourced to supplement the roster. The local GP Anaesthetist also participates on the roster.
Please note: Inverell Maternity Unit it the second busiest Level 3 Maternity Unit in NSW. Also critical to have an Anaesthetist to retain visiting specialist to perform elective surgeries including Colonoscopy, Gastroscopy etc. The surgeon's resignation is imminent if anaesthetic services are not available.

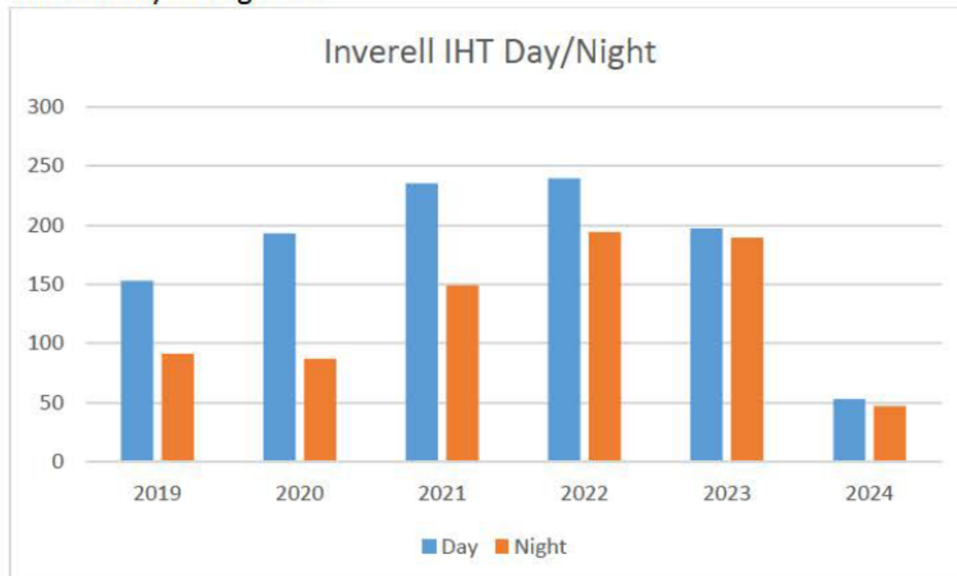
In relation to Recommendations 3 28 and 29
No Action to improve but regressed and the below tables will show the statistics for Inverell Hospital Transfers for the last 5 years and including only the first 2 months of 2024. The data shows that the number of transfers from Inverell Hospital is progressively getting worse with a peak of 36 transfers in February 2024..

Inverell Transfers to Armidale

Year	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec	TOTAL
19	15	10	11	23	23	19	21	24	24	19	13	19	221
20	20	10	12	19	19	14	24	13	21	23	23	28	226
21	17	23	25	28	28	28	26	26	26	24	30	26	307
22	27	26	35	34	40	32	37	33	31	25	18	23	361
23	29	21	28	28	28	20	35	25	29	25	36	28	332
24	30	36											66



Inverell Day Vs Night IHT



The above is only one method of transport of patients out of Inverell.

NSW Ambulance also transport patients from Inverell via rotary winged and fixed winged aircraft. We don't have accurate numbers to provide but it is substantial.
There are also transfers of a number of patients from Inverell via Non-Emergency Patient Transport (NEPT) services. These additional transfers indicate that **even low acuity patients are being transferred** from their hometown in lieu of providing expected services in the Inverell District Hospital.

Community Transport is also provided by volunteer drivers to medical appointments due to no availability of specialists to Inverell.

Indigenous health services (including Recommendations 23, 31, 32, 33, 34, 35 and 43)

Recommendation 23 141 That NSW Health, in conjunction with The Australian and New Zealand Society of Palliative Medicine, the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians and the Aboriginal Health and Medical Research Council of NSW urgently establish a palliative care taskforce to: • plan palliative care access and services of equivalence to those living in metropolitan areas • map who is currently providing palliative care services and their level of training, as well as where these services are offered • establish an agreed, uniform state-wide platform for the collection of palliative care and end of life care data to allow for clinical benchmarking of regional palliative care services • investigate and promote innovative models of palliative care services • ensure culturally appropriate palliative care services are available to First Nations peoples.

No Updated Actions known

Recommendation 31 160 That NSW Health acknowledge the significant cultural barriers that telehealth poses for First Nations communities and work to ensure face-to-face consultations are prioritised.

Telehealth has been an improvement and worked really positively for First Nations communities.

Recommendation 33 161 That NSW Health and the Local Health Districts, particularly those located in rural, regional and remote areas, prioritise building their Indigenous workforce across all disciplines, job types and locations. This should include additional funding targeted at increasing the number of Aboriginal Care Navigators and Aboriginal Peer Workers.

No updated additional funding.

Recommendation 34 162 That NSW Health and the Local Health Districts prioritise formalising partnerships with all Aboriginal Community Controlled Health Services to support the delivery of health services and improve the health outcomes of First Nations people in New South Wales. These partnerships should include formal documentation of service delivery responsibilities and expected outcomes.

No updated prioritising or formulation has occurred ..but has regressed. The LHD informed that a decision was made to take established existing Aboriginal designated specialist services from Armajun Aboriginal Medical Service without consideration of cultural appropriateness.

Recommendation 35 162 That the NSW Government mandate the requirement for each Local Health District to have at least one Indigenous community representative on the governing board.

There has been an Indigenous Representative on the LHD Board for some time prior to October 23

Recommendation 43 182 That the rural and regional Local Health Districts work with rural and remote communities to develop Place-Based Health Needs Assessments and Local Health Plans in collaboration with the Department of Regional NSW, local government, education, human services, community services, community and First Nations organisations and local health providers that are responsive to the variations in determinants, lifestyle and disease burden for each community and its population.

No updated Action

Recommendation 11 75 That NSW Health work with the Australian Government collaboratively to immediately invest in the development and implementation of a **10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy.** This should be done in consultation with rural, regional and remote local government, schools, community services, human services, unions, professional organisations, general practice, pharmacists and community organisations. It should set out a clear strategy for how NSW Health will work to strengthen and fund the sustainability and growth of rural, regional and remote health services in each town including quantifiable targets for tangible improvement in community-level health outcomes, medical and health workforce growth, community satisfaction, and provider coordination and sustainability. It must also address hospital and general practice workforce shortages including General Practitioner, nurses and midwives, nurse practitioners, mental health nurses, psychologists, psychiatrists, counsellors, social workers, paramedics, allied health practitioners and Rural Generalists.

No Updated Action to the 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy however one very encouraging action was The LHD hosted the Rural Medical Recruitment Forum in Tamworth on 22 March 2024 which was well attended by both staff specialists, GPs and VMOs from across the rural area and well received with an action plan currently being developed based on the feedback from the forum. The Inverell contingent felt they were listened to collaboratively and openly and with respect to what they conveyed.

Recommendation 5 36 37 That NSW Health and the rural and regional Local Health Districts actively engage with local community groups and charities to understand the services and resources they provide, and to ensure that where possible and appropriate, service gaps are filled by government.

No updated Action we are aware of this changing. The Inverell Forum was fortunate to have a presentation from Sophie who is the staff representative commissioned to work with all committees to be strengthened and have meaningful representation bridging from Community to the Hospital.

Recommendation 10 74 That the NSW Government work with the Australian Government to establish a Rural Area Community Controlled Health Organisation pilot, with a view to evaluating and refining it for rollout in all areas of New South Wales where existing rural health services do not meet community needs.

No updated Action we are aware of no Pilot programme.

Recommendation 30 That NSW Health: • commit to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities • commit to a model of care under which virtual care technology is used to supplement, rather than replace, face-to-face services 146 • where virtual models of medical care are operating, roster additional suitably trained nursing staff to assist in the provision of the physical care usually attended to by the medical officer • provide staff members with training on how to effectively use telehealth and other virtual models of care • create a public information campaign specifically targeted to rural, regional and remote communities in order to assist patients to effectively engage with virtual care, including factsheets and checklists to set expectations and support positive interactions • ensure that the use of virtual care, if required, is undertaken in consultation with community members, health providers and local governments in rural, regional and remote areas • investigate telehealth cancer care models to improve access to cancer treatment and care including the Australasian Tele-trial model to boost clinical trial participation in regional areas.

Yes there is an improvement and would be good to provide more information details and education for the public to have them aligned with the new model of care.

Recommendation 42 That the rural and regional Local Health Districts: 182 • review, reinvigorate and promote the role of Local Health Advisory Committees to ensure genuine community consultation on local health and hospital service outcomes, and health service planning • investigate methods of better informing communities about the services that are available to them, and publish additional data such as wait times and minimum service standards for the facilities within their remit.

No updated action However implementing Rec 3 or 42 would reverse the current negative publicity.

Recommendation 43 182 That the rural and regional Local Health Districts work with rural and remote communities to develop Place-Based Health Needs Assessments and Local Health Plans in collaboration with the Department of Regional NSW, local government, education, human services, community services, community and First Nations organisations and local health providers that are responsive to the variations in determinants, lifestyle and disease burden for each community and its population.

No updated action nor has this ever happened at AMS

Recommendation 44 183 That the NSW Government adopt a Health in All Policies framework (similar to the policy in South Australia) to ensure that the health of people in New South Wales is central to government decision making, and which recognises that community physical and mental health is a responsibility of all Ministers and Departments of government. Further, such a framework should include a requirement that all decisions of government are assessed to determine the impact on human and environmental health to ensure a whole-of-government ownership of health outcomes for people living in New South Wales.

No updated action known.

Improvements we wish to note that perhaps do not reflect here specifically;

1. **VAS (The Virtual Admission system) has been introduced in the Inverell Hospital and enabled admissions to occur with those patients who do not have a Dr locally. VAS is an improvement as we don't have an admitting Dr at the hospital. Howbeit this does cause extra admin responsibilities for Nursing staff.**
2. **The Forum had a presentation of the work being carried out to strengthen local communities and this is in progress at this time.**
3. **Inverell has a palliative care nurse and generally each GP sees their own palliative care patients whether in their practice or at home or hospital depending on each patient's needs. We can call the palliative care teams elsewhere for phone support if needed.**
4. **A Rural Health forum on 22/3/2024 held in Tamworth to look at issues to try to develop strategies to build up local workforce. This seemed to be a positive step in the right direction to hear our voice.**
   No outcome published as it is still in progress.

Most critical regressions specifically are;

1. **Inverell has one Anaesthetist who also practices as a GP in a busy local surgery**
2. **Two other Anaesthetists, with 30 years of combined experience and no incidents, have been terminated due to them not having updated passed examination status.**
3. **No visiting Specialists to the general Population, with the exception of an eye specialist.**
   Visiting specialists provided by the AMS only available to First Nations population.
4. **Impending loss of visiting surgeons if no anaesthetist**
5. **Dangerous delays in treatment (including caesareans) due to no Anaesthetist**
6. **We have also lost our long term ED Locum leading to more piecemeal rosters with ongoing gaps in anaesthetic/ED/urgent care clinic.**