Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Hearing – 19/03/2021

Questions on Notice

QUESTION 1 – Page 58

The Hon. WALT SECORD: Mr Minns, in your opening statement you said that more money was not a solution to attract doctors. I wrote that down as you were saying it. You said it was market failure. Do you stand by that in the context of what we have heard today, what we have read recently and what Dr Lyons has said about a lack of GPs and a reluctance of GPs to go to rural and regional areas? Paying them more would not attract more doctors?

Mr MINNS: The first point to note for GPs is that they are provided with more payments under the Medicare system, under the MBS system, to work regionally. It is quite considerable. That already exists in the framework and we would happily provide that detail to the Committee on notice.

The CHAIR: Thank you.

ANSWER

All doctors who bulk bill are able to claim Medicare bulk billing incentives. Doctors in rural locations, classified as Modified Monash (MM) 2 to 7, are eligible to claim the higher threshold rural bulk billing incentives.

	Rural Bulk Billing Incentives MM2-7	Bulk Billing Incentives- MM 1
MBS Item	Item Fee	Item fee
10991	$ 9.65	$ 6.40
64991	$ 9.10	$ 6.00
74991	$ 9.10	$ 6.00

Source: https://www.health.gov.au/sites/default/files/documents/2019/12/bulk-billing-incentives---fact-sheet.pdf.

The Australian Government Workforce Incentive Programs provide financial incentives for health professionals to work in rural and regional locations. The program has a doctor stream and a practice stream.

Under the Workforce Incentive Program Doctor Stream, doctors providing primary care services in Modified Monash 3 to 7 locations are eligible for an annual payment of between $4,500 and $60,000, depending on the location. Calculation of payment is based on services provided within eligible locations and the length of time a doctor has been on the program. The maximum annual payments available to medical practitioners across each MM category at each Year Level are:

Location (MM)	Year 1	Year 2	Year 3	Year 4	Year 5 plus
MM 3	$0	$4,500	$7,500	$7,500	$12,000
MM 4	$0	$8,000	$13,000	$13,000	$18,000

MM 5	$0	$12,000	$17,000	$17,000	$23,000
MM 6	$16,000	$16,000	$25,000	$25,000	$35,000
MM 7	$25,000	$25,000	$35,000	$35,000	$60,000

Source: https://www.health.gov.au/initiatives-and-programs/workforce-incentive-program/doctor-stream/payment-amounts

Under the Australian Government Workforce Incentive Program Practice Stream, eligible practices in all locations can receive incentive payments of up to $125,000 per year. The incentive payment amount depends on practice size and the hours worked by the health professionals at the practice. A rural loading of 20 to 50 per cent is applied on top of the Program Practice Stream incentive payments to practices located in MM 3-7 locations.

Visiting Medical Officer General Practitioners (GPs) providing hospital services in eligible NSW Health rural hospitals are paid according to the Rural Doctors' Settlement Package.

The Package rate is calculated and paid by NSW Health at 140 per cent of the current Medicare Benefits Schedule fee. Fees under the Package are indexed from 1 August each year.

QUESTION 2 – Page 59

The Hon. WALT SECORD: You said in your opening statement that 27 per cent of adverse events—you said there were fewer adverse events in rural and regional hospitals. What is an adverse event?

Dr LYONS: Proportionally, I said, for the occupied bed days in admissions. So these are the events that go into the Incident Information Management System that we have across New South Wales, which is where, for any situation where there is a near miss or a concern about the care that is provided, staff have the ability to log that. Those are tracked across the whole system and we look at the comparisons of those incidents. They are categorised into severity. So you might have heard of severity assessment codes [SAC] 1, 2, 3 and 4?

The Hon. WALT SECORD: Yes, I am familiar with that.

Dr LYONS: That is the system that I was referring to.

The Hon. WALT SECORD: Are those preventable deaths?

Dr LYONS: No. Only the most serious of those are SAC 1. They are not always deaths; they can be where somebody has had something that has led to some complication, a length of stay in hospital becoming longer or having to return to operating theatre. Lots of those go to the SAC 1.

The Hon. WALT SECORD: How many SAC 1s have we had in the past two years in New South Wales?

Dr LYONS: I will have to take that on notice, Mr Secord. Across the whole State?

The Hon. WALT SECORD: Yes. Can you take that on notice and give me a breakdown of how many of those occurred in rural and regional hospitals?

Dr LYONS: Certainly.

ANSWER

The Clinical Excellence Commission has published data on their website regarding the number of SAC/Harm Score 1 incidents between July 2016 to June 2020.

In December 2020, NSW Health completed the transition to the new incident management system called ims+. All incidents are now rated from 1 to 4 (1 being the most serious) using the Harm Score, which replaces the Severity Assessment Code (SAC).

QUESTION 3 – Page 60

The CHAIR: I have a follow-up question. Dr Lyons, you spoke about innovative thinking, solutions and work being done and work that has been done in regard to attracting doctors, specifically GPs, to deal with the shortage in regional, rural and remote New South Wales and also Australia. I am wondering, with respect to nurses and other allied health workers—if you are aware; please take it on notice if you need to—who are integral to the overall provision of the highest possible standard of health care that we can

provide to citizens outside the metropolitan area, what work is being done to provide incentives that may attract them to consider going and living and working in these communities?

Dr LYONS: There is a huge amount of work going on right across the board in all the health disciplines, from the training that goes on through the university sector and having more of that training provided in rural environments.

The CHAIR: I am specifically talking about nurses and allied health workers.

Dr LYONS: Yes. Both of those train through universities and both of those disciplines—the broader disciplines of allied health and nursing—are providing educational opportunities in rural environments across our health system. But I am also aware that, having worked in the rural environment for many years, the ability to attract people from outside into rural towns is often seen as the way to fix the problem, when in fact there are people who live in the community who, if given the opportunity to gain the skills, training, experience and qualifications—that is a workforce that we are keen to try and support as well.

There are pathways within nursing, for instance, where nurses can come in under an arrangement where they come in initially as an assistant in nursing, then receive support for training in the facility to move to an enrolled nurse and then they are supported to gain their registered nurse qualifications. I am aware of examples of those that exist right across the system as well. We provide a pathway for training in the community for people who are already residents in the community, which is quite an attractive thing to do to enable those employment opportunities for people who are residents in the town already. They are already committed to living there. Phil Minns might have some examples of that.

The CHAIR: Sorry to interrupt, but how do people in the community make themselves known or become aware of things like this? Is this something that is advertised and promoted and do people understand that this is in fact there?

Dr LYONS: My colleague might be able to assist.

Mr MINNS: Yes, Chair. One of the branches that reports to me is the Nursing and Midwifery Office. It is a small team but it is completely focused on the professional capability of the nursing and midwifery workforce. That is its role and it exists as its own office because of the importance of nursing and midwifery to the health system; you know, the proportion they represent of our clinical frontline workforce. They administer a range of scholarships for both nurses and midwifery students and employed nurses and midwives. We try to direct those programs to the rural and regional locations. Generally speaking, about a quarter or above of all of the recipients are from rural and regional locations. The Nursing and Midwifery Office [NAMO] has a fund which—

The CHAIR: Sorry. The office of?

Mr MINNS: The Nursing and Midwifery Office.

The CHAIR: Sorry.

Mr MINNS: The Nursing and Midwifery Office has a fund which enables it to move funding around according to need and according to feedback that we get from the LHDs.

The CHAIR: May I ask what the size of that fund is? If you do not know you can take it on notice.

Mr MINNS: I can take it on notice and I can give you a detailed list of all of the different arrangements.

The CHAIR: That would be appreciated.

Mr MINNS: But just a flavour: 37 rural undergraduate scholarships were awarded in 2019-20 and they were for $5,000 each for undergraduate nurses and midwives. But I will give you the whole list on notice.

ANSWER

The Nursing and Midwifery Office (NaMO) is located in the NSW Ministry of Health and is led by the Chief Nursing and Midwifery Officer. NaMO administers the allocation of funding to local health districts and Networks for projects and programs of work that support attraction and retention of the nursing and midwifery workforce. This includes funding for education and upskilling of the workforce, workplace culture development and nurse-led clinical projects to improve patient care and the patient experience. In 2019-20, $4.4 million was distributed across rural and regional LHDs.

One example of how LHDs use this funding is referenced in the NSW Health submission regarding the Western NSW LHD virtual education project. This pilot program, *Transition to Rural and Remote Nursing,* supports supernumerary time for graduate nurses in small rural sites, as well as providing virtual education and support, and development opportunities in larger sites. The aim is to grow and sustain the nursing workforce in these small sites for the future. Four graduate nurses will commence this program in 2021.

NSW Health offers a range of undergraduate and postgraduate scholarships to nursing and midwifery students and employs nurses and midwives in both metropolitan and rural areas.

Rural-specific scholarships

Rural scholarships are targeted to those living and working in rural and regional areas to support and develop the local nursing and midwifery workforce. Scholarships available specifically to the rural sector include:

1. **Rural undergraduate scholarships** are intended to attract local nursing and midwifery students living in rural locations where there is identified workforce supply challenges. These scholarships are available to students who are undertaking a Bachelor of Nursing or Bachelor of Midwifery degree. Scholarships of up to $5,000 are awarded based on the student's residential location and areas of workforce need. In 2019-20, 37 rural undergraduate scholarships were awarded.
2. **Rural postgraduate midwifery student scholarships** are designed to address workforce deficits and increase the viability of small rural maternity services. Scholarships are provided to small rural hospitals for local registered nurses to undertake postgraduate training in midwifery. Scholarships of $85,000 fund a supernumerary student position for 12 months and are allocated on a needs basis. On average, 10 scholarships are awarded annually in various locations. Over 100 scholarships have been awarded since 2011.

General scholarships

These scholarships and grants aim to support nurses, midwives and students to undertake education and clinical placements across metropolitan, rural and regional NSW.

1. **Diploma of Nursing (Enrolled Nurse) scholarships** are offered across NSW. The scholarship includes a position in the Diploma of Nursing program and subsequent employment as an enrolled nurse in a NSW Health facility. The scholarship model links training places to areas of workforce need. From 2013 to 2020, a total of 1,868 scholarships have been awarded. This includes 224 in 2020, of which 80 were for students in rural areas.
2. **Postgraduate scholarships** aim to support the retention and skill development of registered nurses and midwives in NSW Health across a wide range of study areas including clinical specialties, education, leadership and nurse practitioners. In 2019-20, $3 million was provided for 719 nurses and midwives in NSW Health to support their postgraduate study. Of these, 204 recipients (28 per cent) were in rural areas.
3. **Undergraduate clinical placement grants** are awarded to assist nursing and midwifery undergraduate students with travel and accommodation to clinical placements within a NSW Health facility. The grant is awarded dependent on distance travelled to clinical placements over 150 kilometres, and is up to a total of $1,000. In 2018-19, more than 1,000 clinical placement grants were awarded to support nursing and midwifery clinical placements across rural and metropolitan areas at a cost of $568,150.

Aboriginal nursing and midwifery strategy

1. **Aboriginal nursing and midwifery cadetship program** provides cadetships for Aboriginal students undertaking study in an undergraduate nursing or midwifery degree. The cadetship offers the student a study allowance, book allowance, paid work placements and mentoring in an NSW Health facility.
2. **Aboriginal undergraduate nursing and midwifery scholarships** of $1,000 per subject are available to Aboriginal students undertaking a Bachelor of Nursing or Bachelor of Midwifery. 74 Aboriginal undergraduate scholarships were awarded for 2020, of which 31 were for students in rural areas.
3. **Aboriginal postgraduate nursing and midwifery scholarships** of up to $10,000 are available to Aboriginal people currently working as registered nurses or registered midwives in the NSW Health system to support further education and skill development. 12 Aboriginal postgraduate scholarships were awarded for 2020, of which nine were for registered nurses

and registered midwives in rural areas. From 2012 to 2020, 313 cadet positions were awarded. Of those, 157 cadets have successfully completed the program and a further 105 are currently enrolled, or in recruitment (as of 22 February 2021). The number of positions is increasing in recent years, and funding is capped at 105 positions, of which 45 were students in rural areas.

QUESTION 4 – Page 62

The Hon. EMMA HURST: Another issued raised was the lack of certification services available for nurses. The example that was given was that a practice nurse may be the only medical practitioner on site but they are not able to certify a death, for example. Are you aware of some of these issues that have been brought forward, and are steps being taken specifically to address them?

Mr MINNS: They were issues raised by the witness from the clinical nurse practitioner—

The Hon. EMMA HURST: Correct, yes.

Mr MINNS: I think we will concede in the ministry that the ability to have more clinical nurse practitioners in rural and regional locations is something we should aim to do. We do have them there, but they have tended to be picked up more consistently in metro areas, perhaps to do with the specialisation of the nursing function in those instances—I am thinking emergency medicine and paediatric care. But it is quite a commitment to become a clinical nurse practitioner, it is both the education and the 5,000 observed or supervised hours. But, I know from the chief nurse that there is interest in how do we promote and support more clinical nurse practitioners in rural and regional facilities. If you like, the specific question about certification, I will take that on notice.

ANSWER

Verification of Death is a clinical assessment to establish that a person has died. A medical practitioner must conduct the verification of death assessment. Where there is no medical practitioner available to verify death, registered nurses (including nurse practitioners), registered midwives and qualified paramedics can make the assessment.

Under the *Births, Deaths and Marriages Registration Act 1995,* the medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, **must,** within 48 hours of the death:

a) Give the Registrar of Births, Deaths and Marriages, notice of the death and cause of death, and
b) If the medical practitioner is of the opinion that it is impracticable or undesirable to give notice of the cause of death of the person within that time, give the Registrar notice of the death, and of the medical practitioner's intention to sign a death certificate with the cause of death notified as soon as possible after that.

Only a medical practitioner can complete the *Medical Certificate of Cause of Death.* If another medical practitioner has given notice, or the death has been reported to the Coroner under the *Coroners Act 2009, a* medical practitioner is not required to give repeat notice of death.

QUESTION 5 – Page 66

The Hon. LOU AMATO: I just wanted to know whether there has been a reduction in the number of people who are taking up medicine and other health professions.

Dr LYONS: Not a reduction in the numbers that are going into those professions, but there is a trend that is occurring when people come through their initial training into specialisation versus general training. The numbers going into general practice have been reduced over time and the numbers going into the specialities for training have been increasing. That is the trend that we are concerned about because we have got to value general practice training and general training in the specialities like surgery and medicine as well. The trends for health care have gone into specialisation and sub-specialisation, and those things have been valued and rewarded. We have got to start to reward those other aspects that are really important for health care to be provided for communities, particularly in rural and regional.

The Hon. LOU AMATO: Yes, I was just curious there. I know in the trade professions there has been a reduction in the number of young people getting into those sorts of professions and that is having an impact. I was just wondering whether the same was occurring in the medical profession.

Dr LYONS: It is certainly a trend towards specialisation and having expertise in a particular deep and narrow area.

The Hon. LOU AMATO: One field, yes. Thank you, Chair.

Mr MINNS: Chair, if I may—

The CHAIR: Please continue. That is fine.

Mr MINNS: I will table for the Committee a summary document from a roundtable meeting of GP trainees that met in the last quarter of 2020, in which they outline a range of issues that they see as trainees in the GP stream.

The CHAIR: That would be much appreciated.

Mr MINNS: It goes to the question asked by Mr Amato.

ANSWER

Since 2004, there has been a significant increase in the number of domestic and international full fee-paying medical students graduating from Australian universities. Between 2004 and 2019, the number of domestic medical graduates grew by 142 per cent, from 1,287 in 2004 to 3,118 in 2019. Between 2004 and 2019, the number of international full fee-paying medical graduates increased by 149 per cent, from 216 in 2004 to 537 in 2019.[1]

Between 2015 and 2020, there was a 17 per cent decline in the number of eligible applications to the Australian General Practice Training Program (2,301 in 2015 to 1,908 in 2020). During this period, there was a 13 per cent decrease in the number accepting an Australian General Practice Training position in Australia (1,534 in 2015 to 1,329 in 2020).[2]

In NSW, the number of doctors entering the Australian General Practice Training fell from 519 in 2016 to 461 in 2019. The most significant fall was in the Western NSW training region, which saw a 33 per cent fall in first year trainees: 91 trainees started GP training in 2016 and in 2019, 61 trainees started GP training in the Western NSW training region.[3] The Western NSW training region includes the ACT, Murrumbidgee and Western NSW regions. Towns in the Western Training region include Bathurst, Broken Hill, Bourke, Canberra, Cowra, Dubbo, Hay, Griffith, Oberon, Orange, Wagga Wagga, Walgett and Young.

General Practice Registrars Australia (GPRA) represents GP trainees. On 12 September 2020, GPRA hosted a roundtable to discuss problems with GP trainee employment and to explore potential solutions. Following the roundtable, a *Statement from the GP trainees' Round Table discussion on employment arrangements* was made available on the GPRA website at: https://gpra.org.au/wp-content/uploads/2020/10/GP-Trainee-Employment-Round-Table-Communique.pdf. A copy of the statement is also attached.

QUESTION 6 – Page 68

The Hon. NATASHA MACLAREN-JONES: I am also mindful of time so I am happy if you want to take some of the questions on notice to give some more details. I am interested in the rural generalist training program, which you have mentioned in the submission but not in great detail. I think it has been in operation for seven or eight years. Could you just outline how it works, and has it led to an increased number of GPs?

Mr MINNS: The answer to the second question is yes. To do it justice I might take it on notice, because it is not just that program. It is also the Rural General Practitioner Procedural Training Program. They are a suite and they support each other, so we will provide you with a detailed answer on notice.

ANSWER

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[1] Medical Training Review Panel(MTRP) 13th report Tables 2.7 and 2.8; Medical deans Australia and New Zealand (MDANZ) Student Statistics.

[2] RACGP – General Practice Health of the Nation 2020 Report Figure 60, pp 59.

[3] Medical Education and Training Reports 1-4 <https://hwd.health.gov.au/met/met.html>.

There are two programs that support GPs to obtain advanced skills in several different medical specialities: the Rural Generalist Training Program, which offers training for junior doctors training in general practice and the GP Procedural Training Program, which offers training for GPs.

1. NSW Rural Generalist Training Program

The NSW Rural Generalist Training Program is up to four years, depending on the point of entry into the program. The pathway consists of a foundation year, 12 months advanced skills training, transition to an independent practice year, and a consolidation year. Enrolment in a general practice training program is an essential requirement for entry into the NSW program.

The NSW Rural Generalist Medical Training Program is a state-wide supported training program for junior doctors wishing to pursue a career as a rural GP that is able to provide primary care within a community general practice setting, as well as advanced services within a rural hospital.

Once training is complete, doctors have specialist GP qualifications for a Fellowship with either the Australian College of Rural and Remote Medicine, or the Royal Australian College of General Practitioners, and at least one advanced skill.

Advanced skills training is offered in specialties including anaesthetics, emergency medicine, obstetrics, palliative care medicine, paediatrics and mental health, and is undertaken in rural and regional locations. Between 2013 and 2020, 188 Rural Generalist trainees have completed advanced skills training.

The NSW Rural Generalist Training Program started in 2013 with 15 rural generalist advanced skills training positions. It has grown to 50 rural generalist advanced skills training positions available each year. The advanced skills training sites and specialties vary from year to year, and are offered based on annual rural LHD prioritisation.

Rural Generalist Scholarships to the value of $3,000 are offered to each Rural Generalist trainee who starts advanced skills training.

There are two entry points to the Program. Junior doctors can apply for the Rural Generalist Foundation Year or for direct entry to the Advanced Skills Training year. During the Foundation Year, trainees are given information about becoming a rural generalist and provided support, education and career planning guidance. Trainees remain on existing contracts with their employing NSW local health district or general practice for that year. In 2021 there are 50 doctors enrolled in the Foundation Year.

The Program is managed by the Health Education and Training Institute . The program is overseen by the NSW Rural Generalist Medical Training Program State-wide Council, which includes representation from LHDs, Australian College of Rural and Remote Medicine, the Royal Australian College of General Practitioners, Rural Doctors' Association NSW, NSW Rural Doctors Network, Regional Training Hubs, GP Synergy, Remote Vocation Training Scheme, NSW Ministry of Health and rural generalist trainees. Information about the Program is available at: https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/nsw-rural-generalist-medical-training-program

The GP Procedural Training Program

The GP Procedural Training Program started in 2003 to provide training opportunities for GPs and GP trainees in procedural skills. When the Rural Generalist Training Program commenced in 2013, the focus of the GP Procedural Program was to support GPs to obtain advanced skills in a range of specialities.

There are 15 full time advanced skills GP Procedural positions available each year in specialties including anaesthetics, emergency medicine, obstetrics, palliative care medicine, paediatrics, mental health and surgery.

Since the GP Procedural Program began in 2003, over 300 GPs and GP trainees have completed advanced skills training.

QUESTION 7 – Page 68

The Hon. NATASHA MACLAREN-JONES: The other question is in relation to the university outreach work and the new clinical school at Wagga Wagga. I am interested in the arrangement that has been made with the universities and NSW Health, and how that will work towards increasing recruitment of doctors and supporting trainee doctors in regional areas.

Mr MINNS: That is the Murray-Darling Medical Schools Network?

The Hon. NATASHA MACLAREN-JONES: Yes.

Mr MINNS: Okay, we can definitely provide you with a brief on that.

The Hon. NATASHA MACLAREN-JONES: Thank you.

ANSWER

The Murray Darling Medical Schools Network (MDMSN) establishes a series of rurally based medical school programs in the Murray Darling region of NSW and Victoria. In NSW this includes the new Charles Sturt/Western Sydney Joint Medical Program and expansion of the medical programs at Wagga Wagga (University of New South Wales) and Dubbo (University of Sydney). The Australian Government established the MDMSN through a redistribution of existing Commonwealth Supported Places (CSPs).

The Charles Sturt University (CSU)/Western Sydney Joint medical program has been established at Orange. It is a five-year undergraduate program that started in 2021 with 37 Commonwealth Supported Places (CSP). Western NSW Local Health District has worked with the Charles Sturt University (CSU) Medical School to set up a campus in Orange and introduce their first cohort of students into the District. 2021 is the first academic year for the new school and the partnership will develop in time.

It is anticipated that as the partnership progresses, there will be a focus on medical training and meeting the changing needs of rural and regional communities into the future.

From 2021, as part of the Murray Darling Schools Network, UNSW Wagga Wagga is offering the full six-year medical program end to end. The first cohort of 10 students commenced in 2021 and will commence over the next five years. UNSW has created several local employment positions to support the program. This includes the appointment of an Associate Dean, Rural Health based in Wagga Wagga, Director of Medical Education, based in Wagga Wagga, and two support roles to assist students in their first and second year.

The expansion of the UNSW Medical Degree Program in Wagga Wagga will occur concurrently with the expansion of the Wagga Wagga Rural Clinical School to a new three-storey Biomedical Centre located on the Wagga Wagga Base Hospital campus. The land has been contributed by NSW Health and construction will commence in 2021.

When rural students are trained locally, there is a greater likelihood they will remain and practice in their local community. Students will undertake placements in a variety of rural hospitals across the Murrumbidgee region. It is anticipated that the ability to complete an entire degree in Wagga Wagga will have a significant impact on medical service provision in rural areas beyond just Wagga Wagga.

The University of Sydney School of Rural Health at Dubbo provides medical students the opportunity to undertake some of their training in a rural location. Starting in 2022 as part of Murray-Darling Medical Schools Network, the School of Medicine at Dubbo will deliver the University of Sydney four-year medical program end-to-end.

All medical graduates of an Australian medical school must complete a 12-month internship to be eligible for general medical registration with the Medical Board of Australia. The NSW Rural Preferential Recruitment Program supports junior doctors working their first two years (internship and second postgraduate year) in a rural location.

In 2021, there are 150 Rural Preferential Recruitment positions, which is an increase from 75 in 2012. Rural preferential positions are available at a number of hospitals: Albury, Broken Hill, Coffs Harbour, Dubbo Base, Lismore Base, Manning Rural Referral, Orange, Port Macquarie Base, Tamworth Rural Referral, Maitland Hospital, Tweed Hospital, Wagga Wagga.

QUESTION 8 – Page 69

The Hon. NATASHA MACLAREN-JONES: Just to end on a lighter note, one last thing that I am happy for you to take on notice. We have had a lot of witnesses today mention the State-Federal divide and funding and things. Could you provide a bit more detail to the Committee in relation to the Bilateral Regional Health Forum and how that has been operating over the past 18 months? We obviously hear about it in the media but not a lot of general detail, so I think it might be interesting.

Dr LYONS: Happy to do that, and we can also talk about our relationship with the primary health networks, our focus on a "one health system" mindset and the work we are doing to set a standard for how we want things to work across the whole of the State.

ANSWER

The Bilateral Regional Health Forum (BRHF) was established in 2019 to support the health needs of people in rural, regional and remote NSW. It brings together stakeholders to discuss rural health issues and monitor Commonwealth and NSW governments' commitments to improving regional health outcomes in NSW.

It is co-chaired by The Hon. Brad Hazzard MP, NSW Minister for Health and Medical Research and The Hon. Mark Coulton MP, Commonwealth Minister for Regional Health, Regional Communications and Local Government.

The forum includes representation from NSW and Commonwealth governments, rural local health districts, primary health networks, Aboriginal Community Controlled Health Services, Rural Doctors Network and Association, and senior leaders in the NSW Ministry of Health and Commonwealth Department of Health.

The BRHF has met twice with the inaugural forum held in Wagga Wagga in December 2019, and the second in Dubbo in November 2020.

At the inaugural forum, it was agreed that NSW and the Commonwealth will collaborate to:

- develop regional collaborative funding models to ensure general practitioners (GPs), nurses and allied health staff are attracted to work and stay in regional and rural areas
- further develop training programs to support GPs and rural generalists into rural practice
- build resilience and mental health support in the regions
- develop attractive funding and employment models for doctors in training to work across hospitals and General Practice
- share and scale successful regional workforce and service initiatives.

At the most recent meeting in November 2020, representatives agreed to a number of commitments, including:

- progressing the National Medical Workforce Strategy through collaborative workforce planning and improved data sharing
- trialling a single employer model in the Murrumbidgee Local Health District
- jointly investigating approaches to improve communication and build community understanding of virtual care and telehealth.

The next BRHF is currently in planning stages, likely to be held in Broken Hill in July 2021.

More information about the BRHF and the communiques from meetings can be found on the NSW Health website at: https://www.health.nsw.gov.au/rural/Pages/bilateral-regional-health-forum.aspx.

NSW Health, Primary Health Networks (PHNs) and the Australian Government Department of Health are currently finalising the Joint Statement: Working together to deliver person-centred healthcare.

The Joint Statement is a shared commitment to:

- a one health system mindset
- NSW Health and PHNs and working together
- a regional focus backed by the right system support
- planning and evaluating our actions.

Supplementary questions

Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning

QUESTION 1

In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding the current provision of palliative medicine, nursing and care in rural, regional and remote New South Wales?

QUESTION 2

In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding ways to improve both the access and availability of palliative medicine, nursing and care in rural, regional and remote New South Wales?

ANSWER

Q 1 and Q 2

Improving end of life and palliative care is a priority for the NSW Government as outlined in the NSW Government submission to the Inquiry. A range of activities have been implemented following broad stakeholder engagement in 2017. Ensuring priorities are achieved for people in regional, rural and remote NSW is an ongoing focus. Key objectives include increasing access to specialist care, and supporting choices in where people are cared for.

- In regional and rural NSW, enhancements to specialist nursing and allied health workforce are progressing and will add to both service capacity and to provision of holistic care. Nursing workforce is critical for specialist palliative care in regional and rural NSW. Since 2017-18, each LHD has received enhancements for an additional four to eight palliative care nurses. To support implementation, work is underway to provide guidance on training pathways, which will enable rural LHDs to develop their local palliative care workforce.
- For many regional, rural and remote health services, palliative care medical specialist cover is provided via a consultant liaison, in-reach and/or virtual models. In response to concerns about supply and isolation of practitioners, a flexible approach has been taken to implemention of medical specialist enhancements. This includes allowing rural LHDs to enhance or establish fly-in fly-out arrangements and/or service agreements with non-government organisation services, if these align with their local needs.
- Implementation of virtual care, where it is appropriate, has increased significantly and will continue to be a key enabler of coordinated and multidisciplinary specialist palliative care.
- Work is ongoing to develop the approach for additional medical specialist cover for regional and rural NSW, and to review availability of after-hours palliative care support. Further plans will be agreed for these projects by end 2021.

Of the $201 million palliative care funding enhancements that have been announced for NSW since 2017, around $75 million benefits regional and rural LHDs in NSW.

Additional detail about initiatives included in the submission in regional and rural NSW is provided:

- By 2022-23, once all enhancements are implemented, there will be 133 new specialist palliative care workforce positions for regional and rural LHDs.
- 64 per cent (509 places) of the palliative care education and training places provided across NSW in 2019-20 were in rural and regional LHDs.
- As part of the commitment of $2 million over four years (2019-20 to 2022-23) for digital solutions to improve access to palliative care in regional and rural NSW, local rollout of virtual care technology is starting in Southern NSW LHD and Western NSW LHD in 2020-21. All regional and rural districts will receive direct support under this initiative.
- In 2019-20, 1103 (39 per cent) Last Days of Life home care packages were provided to remote, regional and rural LHDs. The additional non-clinical End of Life Packages in the NSW Health Out of Hospital Care program from July 2021 onwards includes up to 2,000 additional packages (40 per cent of 5,000) for people in regional, rural and remote NSW.

- Families and carers will be further supported through over $1 million per year in additional bereavement and psychosocial support services that has been committed to regional and rural districts.
- The $10 million over four years commitment to refurbish palliative care facilities included $3.4 million allocated to 19 refurbishment projects in rural and regional NSW in the first funding round for 2019-20 and 2020-21. These include improvements in dedicated palliative care units, other in-patient ward areas, family and outdoor spaces, and multi-purpose services (MPSs), which regularly provide care for people at the end of life. The second round of funding allocation is underway for projects in 2021-22 and 2022-23. Priority for funding allocations will be given to rural and regional facilities, including MPSs.
- Under the Comprehensive Palliative Care in Aged Care Measure agreement executed by NSW with the Australian Government, $6 million of Commonwealth funding has been allocated to rural and regional LHDs to enhance specialist palliative care in residential aged care facilities.
- Pilots of the new advance care planning and palliative care tools for the NSW electronic medical records (eMR) have been completed. Additional funding has been provided to eHealth NSW for supported roll out of these tools in rural and regional LHDs in 2020-21. These eMR tools are a key enabler to improve quality and continuity of care.

In addition, the NSW Rural Generalist and GP Procedural Training Programs offer training in palliative care medicine. Palliative care medicine advanced skills training commenced in 2016 with one trainee and three training sites through the NSW Rural Generalist Training Program. There are now seven sites offering palliative care medicine training for rural generalist trainees, located in Berry, Broken Hill, Coffs Harbour, Lismore, Manning Base (Taree), Maitland and Wauchope hospitals. Ten rural generalist trainees have completed palliative care medicine advanced skills training between 2016 and 2020.