13 May 2021

NSW Parliament Portfolio Committee No. 2 – Health
C/O Mr Chairman, The Hon. Greg Donnelly, MLC
Parliament House
Macquarie Street
SYDNEY NSW 2000

To the Portfolio Committee,

NSW Rural Doctors Network response to supplementary questions from the NSW Parliament's Inquiry into the health outcomes and access to health and hospital services in rural, regional and remote New South Wales

On behalf of NSW Rural Doctors Network (RDN), I would like the thank the Portfolio Committee for the opportunity to provide evidence as a witness to the hearing on 19 March and respond to supplementary questions that have subsequently been requested by the Committee.

As indicated in our original submission to the Inquiry, RDN is a not-for-profit, non-government charitable organisation that provides solutions to support the multidisciplinary rural health workforce. RDN acts as the Australian Government's designated Rural Workforce Agency for health in NSW, and is the NSW fundholder for Rural Health Outreach and range of associated health workforce and service programs.

RDN has responded to the Inquiry's supplementary questions from our vantage point as a specialist in health access solutions and health workforce knowledge of the NSW rural health system. RDN has developed knowledge and expertise through many years of working with a vast network of rural health practitioners, communities, organisations and government to identify needs and support solutions.

In responding with RDN's understanding of the current status of service provision and opportunities to improve, RDN will also take this opportunity to acknowledge the many committed individuals and organisations who have and continue to contribute their energy and expertise to providing palliative care, nursing and care services for rural communities. Whilst there are opportunities to improve, we believe it is important to celebrate the strengths and commitment of the rural health workforce and the organisations that support them.

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NSW Rural Doctors Network activities are financially supported by the Australian and NSW governments

The Inquiry's supplementary questions and RDN's responses are included below.

1. ***Question: 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?***

1.1. Palliative care – current provision

1.1.1. RDN believes there is generally less access to general and specialist palliative care service for people living in rural NSW. Palliative care in remote and rural settings can lack consistency in expertise and knowledge to support patients and their families and therefore may lead to suboptimal care in some areas. Rural communities would benefit from receiving palliative care services both in hospitals settings as well as people's homes and residential aged care facilities. Given the lower number of palliative care specialists in rural areas, it is likely that more of their care would need to be provided by the local nurse and GP workforce.

1.1.2. There is a need to access more palliative care specialists in remote and rural areas to ensure an effective rural palliative care training pipeline, starting with medical students, and to ensure an increase in palliative care training pathways for rural generalists and physicians.

1.1.3. RDN delivers long-term palliative care outreach services that involve medical specialists who visit rural communities on a regular basis. These services were established to increase access for rural communities in partnership with the NSW government and regional health agencies within the last 15 years. The palliative care outreach services generally involve:

- urban hospital staff specialists who are accompanied by registrars;
- consultant models where the emphasis is on providing specialist advice to local nursing and medical staff who provide the vast majority of palliative care directly to patients;
- an emphasis on upskilling local staff; and
- services that report a low number of patients who identify as Aboriginal.

1.1.4. The involvement of registrars in palliative care outreach services acts as a significant enabler to attracting permanent providers to rural locations and succession planning. It can take up to two years to recruit replacements for existing specialist providers and some outreach visits have been suspended whilst a replacement is sought.

1.2. Nursing and care – current provision

1.2.1. RDN's annual Health Workforce Needs Assessments have identified a nursing workforce shortage in rural NSW and demand for the number of nurses is increasing in both health and aged care settings. A January 2020 analysis of nursing recruitment activity indicates a greater than 50% increase in nursing job ads and a 34% increase in aged and disability care ads in regional areas since 2012. The annual growth rate in job ads in NSW from 2019 to 2020 was 17% for aged

and disability care ad 7% for nursing [1] . Rural areas depend heavily on candidates from other areas to fill positions. There is an opportunity to consider the mobility between the nursing workforce and other sectors such as retail, hospitality and tourism which may present both opportunities and risks.

1.2.2. RDN expects there is a shortage in the aged care workforce available to residential and at home settings in rural areas. It is estimated that one third of all current job vacancies occur in rural areas despite the recent cessation of job keeper subsidies. The disproportionately high general vacancy rate in rural arears is likely to impact the workforce available to support aged residents in rural NSW.

1.2.3. RDN is aware of limited culturally safe aged care and support services for aging Aboriginal people in rural NSW. RDN participated on the 2017 Aged Care Indigenous and Rural and Remote Think Tank that acknowledged a poor historical approach to Aboriginal aged care; challenges relating to staff turnover affecting service continuity; dislocation and isolation impacts on ageing Aboriginal peoples their carers, families and communities; limited services for people with high care needs; and difficulties accessing 'My Aged Care' and other government support programs.

2. Question: 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?

2.1. Palliative care – To improve rural communities' access to high-quality palliative care services, the following opportunities are recommended for consideration:

2.1.1. Provide incentives for palliative care specialists to work in rural communities either as locally-based providers or long-term outreach services. This would include supporting local and visiting palliative care specialists to provide upskilling to rural nurses and GPs.

2.1.2. Palliative care specialist registrars should be encouraged to participate in rural practice. This could include reinforcement of NSW Rural Generalist Program's advanced skills training modules and increasing rural registrar positions where a year or more their specialist training is undertaken in a regional or rural location with supervision by regionally-based physicians – telehealth supervision options should also be explored. In addition, urban-based registrars should be supported to participate in regular outreach service provision to rural communities.

2.1.3. An emphasis on developing the palliative care skills of rural nurses, GPs and support workers should be considered and could include:

- Developing an Education and Training Framework for End of Life (inclusive of palliative care) similar to that developed by Clinical Excellence Queensland.

[1] *Source: SEEK, 2020. SEEK Healthcare Pulse Report. https://www.seek.com.au/employer/hiring advice/assets/SEEK_Healthcare_Pulse_Report_August_2020.pdf*

The purpose of the framework would be to improve consistent high quality palliative care services available to rural communities through the provision of training for specialists, other clinicians, support care workers and communities;

- Support GPs and GP registrars to uptake palliative care as a specialty within the Rural Generalist Medicine training pathway through appropriate funding, streamlined pathways and access to supervision; and
- Support nurses to provide palliative care services including incentivising and increasing access to palliative care training and expanding their scope of practice to provide care.

2.1.4. Support regionally and rurally-based palliative care service to be culturally safe by seeking advice from Aboriginally Community Controlled Health Services on how to implement practices that are culturally safe: This may include training and maintain staff's cultural knowledge, developing and attracting an Aboriginal palliative care workforce, and developing palliative care service models that acknowledge Aboriginal peoples' connection to land and the desire of any to die well on Country.

2.2. Nursing and care – To improve rural communities' access to high-quality nursing and aged care services, the following opportunities are recommended for consideration:

2.2.1. Incentivise the long-term retention of nurses to practice in rural health and aged care settings by supporting legislative changes, training and opportunities to increase their scope of practice which would also be accompanied by commensurate remuneration. Studies of nurse practitioners in North America and allied health assistants in Australia demonstrated that training, certification, legislation and developing models of care were required to be affective. Major barriers to recruiting nurse practitioners to rural areas was the absence of appropriate legislation to allow nurse practitioners to practice to the full extent of their licensure. Several studies have demonstrated financial incentives had a positive impact on nurse recruitment and retention and acknowledge that other elements, such as location, practicing to scope and family dynamics, influence the longer-term impact of financial incentives [2] .

2.2.2. Establish scholarships placement programs for nursing students. This could be modelled on NSW Health and RDN's Rural Resident Medical Cadetships or other immersion style programs that supports students and pre-vocational trainees the chance to spend time over the course of their training in a remote community with an individual professional mentor, community host and contact.

2.2.3. Create clear employment pathways and promote rural health career opportunities to pools of urban based nurses and nursing students; and promote the uptake of rural nursing as career option for mobile workers in other industries which may include retail, hospitality and tourism.

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[2] *Source: Walsh S , Lyle D, Thompson S, Versace VL, Brown LJ, Knight S, Pit SW, Jones M. 2020. Chapter 4 The role of national policies to address rural allied health, nursing and dentistry workforce maldistribution. Medical Journal of Australia* https://onlinelibrary.wiley.com/doi/10.5694/mja2.50881

2.2.4. A collaborative, rather than competitive, approach to aged care and hospital nurse workforce solutions is recommended to achieve optimal outcomes for patients, aged care residents, their carers and communities. This would involve state and federally funded organisations collectively considering needs and coordination resources to provide high quality health and aged care services. Examples of collaborative workforce planning includes the Collaborative Care program currently being implemented in five subregional areas in NSW.

2.2.5. Aged care services provide to Aboriginal Australians in rural NSW will improve through co-designing services and models of care with Aboriginal consumers and seeking advice from the Aboriginal Community Controlled Health Sectors. Beneficial factors to consider may include acknowledging a generally poor history of service provision for ageing Aboriginal people; implementing mechanisms for training staff and maintaining knowledge of culturally safe practice including in facilities with high turnover; increasing and supporting the Aboriginal aged care workforce; supporting aged-care models that minimise the dislocation and isolation Aboriginal people, their families and communities; and providing culturally safe care navigation support for Aboriginal people seeking to use mainstream aged care services.

Thank you again for the opportunity to present evidence to the Portfolio Committee and respond to these supplementary questions. RDN acknowledges the importance of this and its findings to inform the continuing provision of health services including palliative care, nursing and care services in remote, regional and rural NSW.

I trust this submission is valuable to the inquiry and please do not hesitate to contact
if the Portfolio Committee would like any further input or discussion with RDN.

Yours sincerely,

Richard Colbran
Chief Executive Officer