Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales

Hearing – Tuesday 18 May 2021

Supplementary Questions

Mrs Alison Campbell, Member, Warren Health Action Group

1. **In addition to what is contained in your evidence provided at the public hearing, do you have any further comments regarding the current provision of palliative medicine, nursing and care in Warren and the surrounding area?**

Palliative Care

Warren MPHS was built in 1999/2000 with 12 acute care beds across 8 rooms and one of the single rooms was fitted out for use as a palliative care room as required. The room includes an ensuite bathroom, kitchenette and sofa bed for family members. It opens out onto a private outdoor space beautifully landscaped and allowing for families and visitors to spend time with the patient without moving through the hospital. In 2013 the staff at Warren MPHS received an excellence in primary palliative care award. Warren has a Volunteer Palliative Care Group who raise funds for any additional fittings or fixtures required and pull a roster together to sit with End of Life patients when needed and requested by the patient /family and nursing staff. The community of Warren who have a choice nearly always request to return to Warren to be looked after, despite being a hospital bed, it is considered home.

The nurses at Warren MPHS strive for best practice at all times with the area of palliative care medicine being no different, however their supporting resources within the LHD are dwindling.

- If there is no GP in town and a client wishes to have end of life care at home there seems to be a very grey area for the community nurses as to who is responsible for completing the death certificate / expected death at home form / NSW Ambulance Palliative care plan documentation.
- It is very difficult to organise a review of a patient at home when there is no GP available and the LHD Virtual Rural Generalist Service is only available at the MPHS. It is extremely difficult for community nurses to organise a home visit even when there is a GP due to time constraints of sole practitioners in small rural communities such as Warren.
- The 48-hour Palliative Care Home Support Program (PCHSP) provided by Hammond Care needs additional funding to allow for travel in rural areas. If there is no provider available locally that can subcontract the job from Hammond Care a provider needs to travel from further away and this travel time is included in the 48 hours allocated for personal care. It is a great program allowing support day or night in blocks of time that suit the individual, however there needs to be additional travel money allocated for patients in rural and remote areas to give it the equity of its metropolitan counter parts.
- Lourdes Hospital in Dubbo supplies the community palliative care consultancy service into Warren. They are no longer always available to travel due to their significant client load. Traditionally they met with the patients and staff face to face and provided training at the same time. The virtual system has become episodic care focused and removed the requirement for nurses to meet each other, assess each other's skill base and supply education as required. Also assess the patients surrounds, supports and meet with extended family.

- WNSW LHD has no permanent palliative care physician. An outreach service from RPA in Sydney is a band aide measure for patients and staff and not readily accessible at all times. Palliative care is not confined to business hours.

Nursing

- Obvious nursing staff shortages RNs, EENs and Certificate 3 Care workers.
- Too much reliance on agency staff
- An escalation plan for shifts with increased patient/work loads or emergencies is impossible to implement due to no casual staff to draw from.
- The local Health Service Manager (registered nurse) now oversees two facilities, Warren and Trangie, this is one less set of hands required in emergency situations as they are no longer on site throughout the whole working week
- The Health Service Manager (HSM) does not live locally and again is not available to be relied on afterhours when the escalation plan needs to be implemented leading to nurses feeling even more isolated and unsupported in their work. Permanent HSMs and GPs should live within the communities in which they work.
- A facility with no access to a visiting medical officer, no support from senior management or casual staff to implement an escalation plan leaves existing nursing staff feeling very vulnerable and not supported in emergency situations

Care

- It is obvious that the nursing staff at Warren strive for best practice, however dwindling resources both physically and in the form of infrastructure (eg: loss of 24 hour Xray, residential aged care rooms not designed for 'aging in place') is putting an increased burden on the staff both physically and mentally.
- Use of more and more virtual services with no additional staffing to coordinate and assist visiting clients is eating into the already reduced nursing hours
- More focus on Hospital in the Home, ambulatory care services and integrated care services to replace acute care services has not seen an increase in staffing in the community health team but has seen a reduction in staffing on the acute care side. You can't shift the workload without staffing adequately.
- Warren lacks a dementia specific residential aged care area, increasing care burden.
- Warren does not have enough activity co Ordinator hours for the number of aged care residents. Warren has 16hrs pw for 32 residents, Nyngan has 36 hours pw for the same number of residents. Again, increasing the workload on nursing staff in Warren and depriving residents of holistic care
- Some residents of the Warren Shire travel in excess of 160km to access their local health care in Warren, it is inequitable to expect services that were once locally accessed to travel a further 120km to Dubbo. Eg: Xray and other allied health services.
- Residents in the Aged Care Beds are missing out on allied health services such as OTs, Dieticians and Speech pathologists
- Recruitment and retention of GPs and all allied health staff to work in the community are required. Primary care services need to be more regular, less travel time eating into rostered days, making them more accessible. With minimal private providers in Warren, the govt supported services are unable to cope with the high numbers and people will not travel to the larger regional center of Dubbo due to poor transport.
- Warren rates 3rd in the primary health region for chronic diseases, the Health Services in Warren are at present in decline and to do nothing is not an option.

2. **In addition to what is contained in your 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 Warren and surrounding area?**

- Cease the one size glove fits all model that has been failing small rural communities over the last 10 -15 years.
- Meet with the Warren Health Action Committee to obtain a balanced view on what a small rural community needs for health care are and ideas on how it can be achieved
- Assist small communities to grow their own health professionals locally, it has been done under previous management
- Fund and support the Warren Health Action Committee to work with the community of Warren to develop a trial-ready model/s of care co-designed with an activated grass-roots community which can be implemented by community members to support and improve the capacity, quality, mix, recruitment and retention of a multidisciplinary health team within a rural community. Achieved by ensuring the co-design process is underpinned by the principles of equality, diversity, accessibility, reciprocity, and cultural safety.

RECOMMENDATION 1:

Funding of a purpose built, dementia specific unit at Warren MPS which will;

- improve aged care services,
- simplify aged care services for people living with dementia in the Warren community
- improve residential aged care quality and safety in a local environment.

Suggestion

That representatives of the NSW Ministry of Health travel to Warren to meet with Rotary representatives, Warren Shire Council and the Warren Health Action Committee to progress a dementia specific residential aged care facility to meet local needs.

Recommendation 2:

Supporting and growing a better skilled aged care workforce locally

The greatest gift we can give our elderly is skilled, professional and compassionate staff they know and trust from their local community.

To date the fall back position to attempt to give equity of access to healthcare to all has been to ‘plug the gaps’ with an expensive fly-in, fly-out and short term workforce of GPs, Nurses and Allied Health Staff. This has led to reduced access to services and lack of sustainability of services in Warren.

For our health system and a dementia specific facility to efficiently work we also need professional stable staffing. There is a great lack of up skilling and lack of opportunity for staff, registered nurses, enrolled nurses and aged care workers to advance their skills and career paths at a local level. Some courses are available, but little is being done to promote these.

Suggestion 1:

Career pathways and improved educational support for existing health staff.

The community of Warren strongly believes that we have to 'grow our own'. It is a life course approach and begins with inspiring young people at high school to train in health professions and includes work experience and placement opportunities within their community as part of their education. Departments of Education and Health need to work with the local community.

Funding to co design a range of education strategies and personal and professional supports that are local and innovative community activated solutions that can be developed to address local health and workforce needs.

A satellite version of the very successful Country University Centre model with paid mentor position funded and set up in Warren to support undergraduate training, post graduate training and upskilling of the existing workforce in Warren.

Suggestion 2:

Ongoing individual and family support strengthening networks and collaborations to ensure continuity of care.

Social reform is an important means for achieving better health and community activation leads to communities advocating to build a healthier society. The community of Warren wants to be active in solutions for their community.

Assist our community in developing community partnerships to build on existing momentum in the Warren community. These partnerships would develop innovative and sustainable models to improve health outcomes for people living in Warren. Collaboration would complement existing efforts of local health providers in recruitment and sustainability of a local health workforce.

Recommendation 3:

A Multi-Purpose Service suited to the local community

Warren's health services have become fragmented and siloed over the past 10 years. The Local Health Districts one size glove fits all system has failed the Warren

community. MPS were instigated to offer flexible aged care services that meet the needs of their community. Our MPS needs to once again offer services and be staffed in a manner that supports the Warren community's health needs.

A reminder that some of the MPS Service Principles are:

- All users or potential users of an MPS will have equitable access to services.
- Services will be provided in a way that is culturally appropriate and recognises the rights, dignity and independence of service users.
- Consultation with the local community on health and aged care needs will be undertaken on an ongoing basis.

Table 1: Warren Local Government Area (LGA) population, health, determinants and risk factor indicator data compared to NSW (where appropriate/available)

Priority Area	Subject	Measure	Warren LGA	NSW	Source
Population trends	Population number	Total Estimated Resident Population (ERP), 2016 (Number, N)	2,802	-	HealthStats NSW, 2020
	Vulnerable group	Total Aboriginal Usual Residential Population (URP) (N), 2016	396	-	PHIDU, 2018
		Aboriginal URP %, 2016	14.5	2.9	PHIDU, 2018
		Population (ERP) aged less than 15 years %, 2016	22.8	18.8	PHIDU, 2018
		Population (ERP) aged 65 years or older %, 2016	19.4	15.7	PHIDU, 2018
		ERP Males per 100 females, 2016	102	98.2	PHIDU, 2018
	Median age	URP: Median age (years) , 2016	43	38	Community Profiles Quick Stats,ABS, 2019
	Project population	Projected total Estimated Resident Population (ERP), 2021 (N)	2,728	-	HealthStats NSW, 2020
		Projected total Estimated Resident Population (ERP), 2036 (N)	2,630	-	HealthStats NSW, 2020
	Population change	Projected population (ERP) change (%) from 2016 to 2036	-6.1	28.2	HealthStats NSW, 2020
Health determinants	Service Access	Service accessibility - ARIA+2016 classification	Remote	-	Australian Population and Migration Research Centre, University of Adelaide, 2016
	Socio-economic disadvantage	SEIFA-IRSD, 2016	945	1002	ABS, 2018
	Cultural diversity	% of population born overseas who speak English not well or not at all, 2016	0.00	3.8	PHIDU, 2018
	Disability	% People living with a profound or severe disability, 2016	4.8	5.6	PHIDU, 2018
Health status	Life Expectancy	Life Expectancy, persons, at birth 2018 (years)	82	83.6	HealthStats NSW, 2020
	Health and Wellbeing	Self-reported good or excellent health and wellbeing (%), 2018	80%	-	WNSWPHN Community Health Telephone Survey 2018
	Potentially avoidable deaths	Potentially avoidable deaths rate per 100,000 population, people aged <75 yrs, 2017-2018	127	99.4	HealthStats NSW, 2020
	Potentially preventable hospitalisations	Potentially preventable hospitalisations rate per 100,000, 2017-18 to 2018-19	2795.8	2160.7	HealthStats NSW, 2020
Mental health	Community concern	% of surveyed residents that identified mental health a serious health concern for their community, 2018	20	-	WNSWPHN,2018
	Mental health risk factor	% High or very high psychological stress(based on the Kessler 10 Scale), 18 years and over, 2017-18	12.2	12.4	PHIDU, 2020
	Vulnerable group	% of social developmental vulnerability in children at their first year of school, on average, 2018	5.7	9.2	AEDC, 2019
	Vulnerable group	% of emotional developmental vulnerability in children at their first year of school, on average, 2018	11.5	6.8	AEDC, 2019
	Self-harm	Intentional self harm hospitalisations (all persons) rate per 100,000 population, 2017-18 to 2018-19	112.8	93	HealthStats NSW, 2020
	Self-harm	Intentional self-harm hospitalisations rate, males per 100,000 population, 2017-18 to 2018-19	102.8	68.9	HealthStats NSW, 2020
	Self-harm	Intentional self-harm hospitalisations rate, females per 100,000 population, 2017-18 to 2018-19	149.4	117.9	HealthStats NSW, 2020
Alcohol and drug misuse	Community concern	% of surveyed residents identified alcohol & drug use a serious health concern for their community, 2018	43	-	WNSWPHN, 2018
	Alcohol	Alcohol attributable deaths rate per 100,000 population, 2017 to 2018	22.2	20.0	HealthStats NSW, 2020
	Alcohol	Alcohol attributable hospitalisations rate per 100,000 population, 2017-18 to 2018-19	476.9	514.0	HealthStats NSW, 2020
	Alcohol and illicit substances	Interpersonal violence-related hospitalisations rate per 100,000 population, 2017-18 to 2018-19	107.9	60.7	HealthStats NSW, 2020
Chronic Disease Prevention and Management	Cardiovascular disease	Circulatory disease deaths rate per 100,000, 2017 to 2018	162.2	136.0	HealthStats NSW, 2020
	Cardiovascular disease	Circulatory disease hospitalisations rate per 100,000, 2017-18 to 2018-19	2186.3	1666.3	HealthStats NSW, 2020
	Cardiovascular disease	Stroke hospitalisations rate per 100,000, 2017-18 to 2018-19	145.7	134.9	HealthStats NSW, 2020
	Cancers	Cancer deaths (all causes) rate per 100,000, 2013-2017	236.8	146.1	Cancer Institute NSW, 2020
	Cancers	Cancer incidence (all causes) rate per 100,000, 2013-2017	554.6	492.8	Cancer Institute NSW, 2020
	Respiratory diseases	Asthma hospitalisations rate per 100,000 persons 2017-18 to 2018-19	130.3	142.1	HealthStats NSW, 2020
	Respiratory diseases	Chronic obstructive pulmonary disease deaths rate per 100,000, 2017 to 2018	38.0	24.5	HealthStats NSW, 2020
	Respiratory diseases	Chronic obstructive pulmonary disease hospitalisations rate per 100,000, 2017-18 to 2018-19	580.7	230.0	HealthStats NSW, 2020
	Diabetes	Diabetes prevalence (type 1 and 2 combined)% of total population, 2020	7.6	5.4	NDSS, 2020
	Diabetes	Diabetes-related deaths rate per 100,000, 2017 to 2018	36.8	28.6	HealthStats NSW, 2020
	Diabetes	Diabetes - Type II hospitalisations rate per 100,000 2018-19	153.0	100.5	HealthStats NSW, 2020
	Renal disease	Chronic kidney disease deaths rate per 100,000, 2016 to 2018	71.8	56.5	HealthStats NSW, 2020
	Renal disease	Chronic kidney disease hospitalisations (excluding dialysis) rate per 100,000, 2017-18 to 2018-19	1303.9	1119.5	HealthStats NSW, 2020

Table 2: Warren LGA residents participating in the Western NSW Community Health Telephone Survey, 2018

Top 3 health concerns facing your community	% of survey participants
Alcohol and drug use	43
Cancer	41
Mother and baby health/maternity	26
Top 3 gaps in health services where you live	**% of survey participants**
Medical specialists/specialist services	34
GP access/local access/more GPs	31
Transport/travel distances to medical services	26
Top 3 health service improvements needed	**% of survey participants**
More GPs/better quality GPs	27
More or better specialists/specialist services	21
Hospital access/services	5
Mental health services	5
Transport/travel distances to medical services	5

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