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INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: Australasian College for Emergency Medicine (ACEM)

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Australasian College
for Emergency Medicine

34 Jeffcott Street West Melbourne Victoria 3003, Australia
+61 3 9320 0444 | admin@acem.org.au | ABN 76 009 090 715

Submission to the Inquiry into health outcomes and access to health and hospital services in rural, regional, and remote New South Wales

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Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to respond to the Inquiry's call for submissions on health outcomes and access to hospital services in rural, regional and remote (RRR) New South Wales (NSW).

As the peak professional organisation for emergency medicine, ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine (EM) in Australia and New Zealand. ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an emergency department (ED), regardless of the location of the patient.

As part of our National Program, the federally funded ACEM Emergency Medicine Education and Training (EMET) program supports RRR EDs and the RRR workforce, providing education and training support to 129 NSW EDs, with 13 hub sites offering education, supervision and onsite and virtual training. This makes ACEM well positioned to provide insight into the many factors impacting on the capacity of RRR EDs in provision of care to RRR communities.

It is widely understood that healthcare equity, access and health outcomes in RRR areas are poorer than that seen in metropolitan areas. On aggregate, people who live in rural areas have shorter lives and higher levels of illness and disease risk factors than those in major cities. This can be explained in part because they have poorer access to goods and services, educational and employment opportunities, as well as lower levels of income. Australia-wide evidence shows that:

- The health of rural people is poorer than that of their city counterparts,
- Accessing primary care, dental care, allied health and specialist services is more difficult and, in many areas, requires greater time and expense on travel and accommodation,
- Shortages of health professionals, including doctors, allied health professionals, pharmacists and dentists, become more pronounced with remoteness,
- The health of Indigenous people living in RRR areas is significantly worse than that of their non-Indigenous counterparts,
- The viability of many rural hospitals is uncertain and there has been a serious loss of capacity for maternity services and other procedural care in rural areas,

- Tt is difficult to attract and retain health professionals in rural and remote areas, particularly those who study and train in metropolitan areas, and
- Infrastructure in rural and remote areas for health services and health-related activity is limited and being further eroded by a lack of ongoing investment.

ACEM believes that improving the service provided in EDs, as well as the wider healthcare system, across RRR NSW will unquestionably lead to better patient outcomes. At present, not only is there is large disparity in terms of quality of healthcare provided between metropolitan and regional NSW facilities, but also between the quality of care in different RRR areas themselves. The more remote a facility is, the less likely it is to have an emergency medicine (EM) specialist, with over 50 per cent of patients in remote and very remote areas not having an EM specialist nearby, a figure that improves a little to 30 per cent for patients in outer regional areas.[i]

The challenges in providing equitable access to emergency medical care in rural areas are well documented and include:

- The gap between health service need by communities and the required investment to meet this need,[ii]
- Workforce shortages and maldistribution across all clinical specialties, including under-staffed EDs and difficulties with recruitment and retention of trainees, registrars, emergency specialists and other senior decision makers,[iii]
- Excessive lengths of stay in EDs due to an inability to admit or transfer a patient out to a larger centre
- A lack of acute mental health services,
- Poor clinical governance.

These challenges are addressed below.

1. Adequate Funding to meet Community Need

In NSW, half of the Local Health Districts (LHDs) cover RRR areas; 775,500 square kilometres that accommodates 28 per cent of the population.[iv,v] We note the increased investment into rural and regional hospitals and health facilities in the 2020-21 budget, however long-term underinvestment has left many areas without the service and infrastructure that they need.

The issues faced across the NSW RRR healthcare system cannot be addressed without increased investment. With the current NSW Rural Health Plan due to expire next year, we urge the prioritisation of these challenges both in future planning and in future state budgets.

2. Workforce Challenges

In 2017-18, there were over 1.2 million ED attendances to rural NSW LHDs[vi]. Low numbers of EM specialists (FACEMs, Fellows of ACEM) in RRR EDs in NSW is directly putting people at risk. In metropolitan EDs only 13 per cent doctors working in the ED are not EM specialists, whereas RRR areas 40 per cent of doctors working in the ED are not EM specialists (Appendix One, Table 1).

Despite the growth of the EM specialty, this has not translated to a sustainable equivalent increase in the number of trainees and ACEM accredited fellows (FACEMs) working in RRR areas. Like other medical specialities, recruitment of FACEMs and senior EM decision makers to RRR areas is difficult, resulting in poorer access to emergency healthcare for rural communities. As a result, there is a high reliance on locum staffing in these hospitals. This dependence came into sharp focus recently when border closures left hospitals with insufficient staff numbers. Without clinical leads permanently in place to drive ED care in these settings, the result is a standard of care in our RRR areas that does match that standard patients receive in metropolitan EDs.

The sustainability of the emergency medicine workforce across Australia is affected by increasing workload, workplace culture and health system factors, emergency physician burnout, as well as employment status issues. These issues are exacerbated in RRR areas by the geographic maldistribution of the existing workforce. Despite the growth of the specialty, an equivalent increase in the number of trainees and FACEMs working in RRR areas has not yet occurred, mostly because of the metropolitan requirement. ACEM is currently developing a range of new initiatives with the goal of reducing workforce maldistribution across rural areas.

ACEM's Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce (the G23 Guidelines)[vii] recommends minimum staffing levels required to provide quality patient care. Compared with metropolitan EDs, even fewer EDs in RRR areas have sufficient FACEMS and senior decision makers when benchmarked against ACEM's G23 guidelines, resulting in inequitable access to local specialist emergency care.

Geographic maldistribution of the medical workforce is one factor associated with disparities in patient access to health care, as well as with health outcomes. While differences in health outcomes are multifactorial, and not solely due to workforce disparities, improving geographic distribution will contribute to more equitable health outcomes for rural communities.

3.1 Workforce pressures and limitations in RRR NSW

In 2016 Healthcare Professionals (HCPs) working in EDs in rural and regional NSW identified increased demand for services and a lack of staff as the two greatest challenges facing EDs.[viii] With greater distances between healthcare services and a shortage of health professionals working at those services – with many unable to offer out of hours care – patients in RRR areas often have nowhere else to go except the ED when they need urgent care. This demand puts a far greater pressure on RRR EDs compared to metropolitan EDs and there is a clear disparity between the two.

ACEM's 2019 Annual Site Census for NSW showed that metropolitan EDs had a higher average full time equivalent (FTE) for most ED staff (adjusted for patient volume) compared with RRR EDs, including EM specialists, ACEM trainees, medical officers, and nursing staff, whereas RRR EDs had higher average FTE for other specialists, which include Fellows of both RACGP and ACRRM, as well as a higher average FTE of nurse practitioners. EM physicians have specialist skills in resuscitation and in the diagnosis and management of patients affected by an acute or urgent injury or illness that other specialties cannot provide. Metropolitan EDs had an EM FTE mean number of 12.6, exactly double that of the 6.3 in RRR EDs (Appendix One, Table 1).

The disparity in workforce between metropolitan and RRR EDs does not reflect the size of the respective populations that each serves. In metropolitan EDs there is one FTE EM specialist for every 5396 attendees, whereas in RRR EDs there is one FTE EM specialist for every 7022 attendees (Appendix one, Table 2). EM specialists in RRR areas in NSW provide input into the care of a larger number of patients than their metropolitan counterparts, as do all other types of staff in the ED. It is notably worse for EM trainees in the RRR ED compared to the metropolitan ED, as there are almost double the number of patients per trainee (Appendix one, Table 2).

RRR EDs are struggling to attract EM specialists compared to metropolitan EDs. RRR EDs in NSW are much more likely to report having EM specialist vacancies than metropolitan EDs (64 per cent vs 31 per cent of EDs), with these positions more likely to be unfilled for more than 6 months (Appendix One, Table 3). Vacancies for EM trainees are almost a third more likely to remain unfilled for over six months in RRR EDs in NSW than in metropolitan EDs. These are significant shortfalls in the workforce that are contributing to burnout and stress for many EM specialists working in RRR NSW and ultimately contribute significantly to poor outcomes for patients.

3.2 Attracting and retaining trainees in RRR areas

Surveys of ACEM trainees in Australia show that in 2019 only 54 percent were willing to undertake at least part of their training in a RRR ED, down from 63 per cent in 2018. The same surveys also found that Directors of Emergency Medicine Training (DEMTs) have serious concerns about support for trainees in rural and regional areas, the shortfalls of trainees in smaller hospitals and regional areas, and that there is a need for more rotations to rural and regional areas.[ix] Support for trainees is provided by current EM specialists. In RRR areas

these EM specialists already have greater demands on their workload due to understaffing, resulting in a training system that struggles to attract and then fully support trainees.

Historically it has been evident that despite undertaking specialist training in RRR areas, once trainees have gained their specialist qualification they will move to work in metropolitan areas as there are jobs available there and living metro seems more desirable. This has been a problem for all specialties, not just EM, and has contributed to poorer health outcomes for patients. Encouragingly ACEM may be seeing a change to this trend. In our 2019 survey of recently qualified FACEMs across Australia, the proportion of new FACEMs working in a metropolitan area decreased from 56 per cent in the 2018 cohort of new FACEMs to 46 per cent in the 2019 cohort. While those who worked in a RRR area only remained at 33 per cent, 21 per cent of new FACEMs were working in both metropolitan and RRR areas (as opposed to solely working in one of those areas) in the 2019 cohort of new Fellows, compared with 12 per cent of the 2018 cohort.

New FACEMs who worked outside metropolitan areas were encouraged to provide the reason(s) they chose to work in a RRR location, with the responses reflecting both work and non-work related reasons. The key themes included better lifestyle, job availability and breadth of exposure/skill development when working in a RRR location. While the results of this survey are encouraging, many of our members are still reporting that they are not seeing enough newly qualified EM specialists in their RRR EDs. The results of this survey may only be an anomaly and not reflect a sustainable increase to the RRR workforce. As such, newly qualified specialists must be given more incentives to fill the workforce shortages that are so prevalent across EDs in RRR NSW. We are aware that NSW Rural Doctors Network offers cadetships to medical students in exchange for working for two years in rural NSW once they have graduated, but believe that a more effective and wider ranging scheme that targets recently qualified specialists must be considered to improve the number of specialist doctors in RRR areas.

3.3 EMET program

Since 2011, ACEM's Emergency Medicine Education and Training program (EMET) has been building the capacity of our RRR health workforce – including medical specialists, general practitioners and nurses to confidently provide urgent and critical care across RRR parts of Australia. Through EMET, ACEM and the federal government are delivering meaningful improvement to the patient care and the workforce challenges in RRR areas.

EMET supports specialist doctors (including general practitioners and rural generalists) and other medical practitioners to develop their EM skills, through our Certificate and Diploma programs (with an Advanced Diploma soon to be available). These programs were developed in recognition that a need existed to provide appropriate and additional training to the doctors working in settings involved in the provision of emergency care.

The benefit lays in the fact that the education and training is based mainly in the training doctor's rural hospital workplace but is under the supervision of a trained emergency physician who has additional training as a course supervisor. These programs directly address the constraints doctors working in RRR areas face due to less opportunities for direct ongoing medical education and less ability to take leave for recreational or educational reasons. Indeed, although a national program, a strength of EMET is that local training content is developed in response to needs identified by local communities and health services. The EMET has also reduced the need for RRR hospitals to rely on locums, enabling that money to be better spent elsewhere.

Recommendation one

That a new workforce strategy be developed by NSW Health that ensures more of the NSW workforce, including the substantial number of International Medical Graduates, are trained for work in RRR areas and incentivised to remain there once qualified.

Recommendation two

That the size of the EM specialist workforce in RRR NSW is increased to meet ACEM's Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce.

3. Access Block

Access block is an inability to move patients to appropriate inpatient care from EDs within eight hours of arrival, and is the major driver of overcrowding in EDs, increasing patient harm and mortality, and increasing waiting times, length of stays, and ambulance turnaround times. One of the principal ways in which the impact of access block can be minimised is by taking a whole-of-system approach to the effective management of patients, the workforce and healthcare resources.

Patients are far more likely to have extended stays in EDs in RRR areas than in metropolitan areas in NSW. ACEM's 2019 Annual Site Census for NSW showed that 4.3 per cent of all patients in metropolitan EDs incurred a length of stay of more than 12 hours, whereas in RRR EDs 5.5 per cent of all patients stayed in the ED for more than 12 hours. Furthermore, whereas 0.6 per cent of patients that presented to metropolitan EDs in NSW stayed for over 24 hours, patients that presented to RRR EDs in NSW were almost three times as likely to experience such a delay, with 1.7 per cent of all patients staying over 24 hours.[x] Unacceptable ED stays of this length is linked to poor patient outcomes, including longer inpatient hospital stays after transfer from the ED; increased errors in care; an increased likelihood of dying while in hospital; and increased use of restrictive practices.

Extended RRR ED stays may be due to a number of factors, including lack of ED Short Stay Units (where investigations and observation can be completed prior to eventual discharge home), prolonged waits for inter-hospital transfer, or inpatient specialist units (including Mental Health units) not accepting admissions in alignment with times of patient demand. We also are aware of situations where an inpatient in a RRR hospital is ready to be discharged on a Saturday, but has to wait two days until the Monday when the correct staff are present at the hospital to process the discharge. These all result in bed block and lack of available space for new admissions from the ED, and lead to longer waits for other ED patients. Implementation of contemporary models of care, patient flow initiatives, changes to the management of patients in terms of the provision of enhanced outpatient services, along with appropriate resources and workforce development will enable patients to be discharged in a timely manner and reduce the waiting times for subsequent patients.

Recommendation three

That the bed capacity in RRR hospitals is increased to reflect the number of patients that require admission.

Recommendation four

That mandatory notification must be made to the hospital executive for any patient with an emergency department length of stay greater than 12 hours.

Recommendation five

That mandatory notification must be made to the relevant Health Minister for any patient with an emergency department length of stay greater than 24 hours.

Recommendation six

That contemporary models of care and patient flow initiatives are implemented in RRR hospitals and health services.

Recommendation seven

That there are always members of staff on hand in RRR hospitals that have the clinical experience and ability to safely admit and discharge patients.

4. Mental Health

Mental health presentations have increased in EDs across NSW, yet the pressure caused by these presentations is cited by staff working in RRR EDs to be a far greater challenge than by staff in metropolitan EDs.[xi] Better oversight of the NSW mental health system will result in better outcomes for these patients and it must take in to account that in RRR areas the ED is often the only place that many patients with mental health conditions will present to. Australians living in RRR areas experience a unique contribution of factors that impact upon the availability and accessibility of mental health services. In addition, Aboriginal and Torres Strait Islander peoples face cultural barriers and a lack of mental health services which are culturally appropriate. There is a shortage of psychiatric leadership and trained mental health professionals, particularly in rural areas, so new workforce measures are urgently needed to attract and retain these professionals across the public mental health system.

Once a patient requires inpatient admission to a mental health service, there are often prolonged waits in RRR EDs until suitable transport and personnel are available. An alternative to accommodating such patients other than the hospital ED should be identified and utilised, so as to improve patient care, reduce restrictive interventions including sedation, and increase privacy and dignity for patients.

Recommendation eight

> That the NSW government develop a fully funded rural mental health strategy that addresses the severe inequities in access to safe, culturally appropriate and evidence-based treatment and care experienced by people with mental health needs in remote and rural areas.

Recommendation nine

> Investment in rural mental health workforce development is essential, including staff capabilities, skill mix and role diversification, to deliver the goals of an effective, best practice, comprehensive mental health services system.

Recommendation ten

> Improved physical accommodation within the referring hospital, and preferably not routinely in the RRR ED, should be provided where patients with mental ill health awaiting transfer for inpatient admission are observed pending transfer.

Recommendation eleven

> That transfer arrangements should be streamlined and capacity enhanced to avoid long waits in ED observation rooms where there is a higher likelihood of restrictive practices occurring due to inadequate provision for support for patients with mental health needs.

5. Clinical Governance

Changes to clinical governance can be tied together under the recommendation that NSW Health adopt an evaluation approach so that outcomes are constantly assessed, and governance is continually renewed. The Institute for Healthcare Improvement (IHI) Triple Aim is one such method of an evaluation approach. The IHI Triple Aim is a framework to describe an approach to optimizing health system performance, where the following are pursued concurrently:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and

- Reducing the per capita cost of health care.

The management of resources – including that of the workforce – is inadequate in many RRR areas and the College believes that better training that focuses on improving the health of the NSW population is needed for leadership and management in order to achieve higher quality services for patients. Clinical decision makers must be involved in the clinical governance processes so that patient outcomes can be given better evaluation and improved over time.

It has been reported to us that there is a lack of understanding across other hospital staff (including medical and nursing) and local management regarding the role and responsibilities of FACEMs in some rural and remote sites. Our members have anecdotally reported difficulties in escalating their concerns in the workplace to hospital and LHD executive, and difficulties engaging them in changing processes amid concerns about repercussions given the isolation. Finding another job for a specialist may prove more difficult in RRR areas given the sheer distance between EDs compared to metropolitan areas, and perceived risks to raising legitimate issues can negatively influence specialist engagement in their workplaces.

Management of the RRR ED locum workforce requires better co-ordination and oversight, so that locum medical officers themselves are offered adequate support and educational activities relevant to their workplaces, and that underperforming locums are identified and offered support, rather than as is the case currently whereby staff can move from ED to ED without adequate clinical governance support. This support is best provided by FACEMs who work in RRR ED, however requires adequate resourcing.

6.1 Telehealth

While ACEM is currently developing our position on telehealth, we cannot give a full statement on telehealth. However, it is vital to stress though that telehealth is meant to augment care and not replace it, and that telehealth services must be staffed and resourced appropriately and not add to the daily work of the ED physician in the ED.

Contact

We welcome all opportunities to advocate on behalf of patients and EM clinicians in NSW and RRR areas.

Appendix One

Table 1 Average FTE for ED staff (range provided in brackets), for particular staffing roles in NSW EDs, by remoteness.

Remoteness	EM Specialists mean (range)	Other Specialists mean (range)	ACEM AT Reg. mean (range)	ACEM PT Reg. mean (range)	Medical Officers mean (range)	Non-ACEM Reg. mean (range)	JMO/ Interns mean (range)	Nurse Practitioners Mean (range)	MH Nurses mean (range)	Nurse Educators mean (range)	Total Nursing mean (range)
Metropolitan	12.6 (3 - 31)	1.6 (0 - 4)	10.5 (1 - 38)	5.5 (1 - 27)	12.3 (1 - 45)	4.4 (1 - 13)	15.7 (4 - 39)	4.0 (1 - 25)	3.1 (1 - 8)	2.1 (1 - 4)	101.3 (30 - 287)
Regional	6.3 (2 - 13)	2.3 (1 - 5)	4.4 (1 - 9)	2.0 (1 - 3)	7.7 (1 - 18)	4.4 (1 - 7)	5.8 (1 - 12)	5.6 (1 - 40)	1.5 (1 - 2)	1.5 (1 - 5)	49.9 (27 - 73)

Notes: EM Specialist = FACEM and Paediatric EM Specialists (PEMs). AT Reg = Advanced trainee registrar. PT Reg = Provisional trainee registrar. Medical Officers include CMOs; SMOs; SRMOs; SHOs. Nurse Practitioners includes Clinical Nurse Consultant/ Specialist).

Table 2 Ratio of various ED staffing FTE to ED attendance in NSW, by remoteness.

Remoteness	EM Specialists: Attendance	Trainee: Attendance	Senior Medical Staff: Attendance	All Medical Staff: Attendance	Nursing Staff: Attendance
Metropolitan	1 : 5396	1 : 7874	1 : 1635	1 : 1281	1 : 651
Regional	1 : 7022	1 : 13682	1 : 1903	1 : 1604	1 : 735

Note: EM Specialist = FACEMs and Paediatric EM Specialists (PEMs). Trainee = FTE of ACEM advanced and provisional trainees. Senior Medical Staff = EM Specialists, other specialists, FACEM trainees, non-ACEM registrars and medical officers (MOs); note that Senior Medical Officers excludes junior medical officers (JMOs) and interns. All medical staff = all senior staff, JMOs and interns.

Table 3 Percentage of EDs who reported having unfilled FACEM and trainee FTE; the percentage of those EDs with unfilled FTE for 6+ months

	Unfilled FTE: FACEMs			Unfilled FTE: Trainees	
	Unfilled	Unfilled for 6+ months	Total unfilled for 6+ months	Unfilled	Unfilled for 6+ months
Remoteness	%	%	FTE	%	%
Metropolitan	31.0	20.7	14.8	82.8	62.1
Regional	63.6	63.6	33.7	81.8	81.8

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[xi] ACI (2016) pg 11