Submission No 346

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

Organisation: Western Health Alliance Limited, trading as the Western NSW Primary Health Network (WNSW PHN)

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Western Health
Alliance

Western Health Alliance

Submission to:

Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW

9th December 2020

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1 INTRODUCTION

Western Health Alliance Limited, trading as the **Western NSW Primary Health Network (WNSW PHN)**, is one of 31 Primary Health Networks across Australia, established to support frontline health services and increase the efficiency and effectiveness of primary health care.

Our focus is patients who are at risk of poor health outcomes and working to improve the coordination of their care, so they receive the right care in the right place at the right time. We work closely with key stakeholders including general practice, other health care providers, Local Health Districts, hospitals and the broader community to align services with the health needs of the region.

WNSW PHN is a not-for-profit organisation primarily funded by the Australian Government. Our region covers both Far West and Western NSW Local Health Districts.

Our Vision

Supporting, strengthening and shaping a world class person-centred primary health care system in Western NSW.

Priority Areas

- Aboriginal Health
- Chronic and Complex Care
- Older Person Care
- Maternal and Child Health
- Mental Health and Substance Abuse
- Risk Factors/Prevention
- Workforce
- Access to Services
- Coordination, Integration, Collaboration

Collaboration is a key value of the WNSW PHN and central to achieving our goals. Forming strong partnerships allows us to better focus on our role in driving, supporting and strengthening primary healthcare in our region.

The following organisations are members of Western Health Alliance Limited (WHAL), the company operating WNSW PHN:

- Marathon Health Limited
- Bila Muuji Aboriginal Health Services Incorporated
- Maari Ma Health Aboriginal Corporation
- Country Women's Association of NSW
- Australian Association of Practice Management Ltd
- Services for Australian Rural and Remote Allied Health Incorporated (SARRAH)
- Royal Flying Doctor Service of Australia (RFDS) - South Eastern Section
- NSW Farmers Association
- Rural Doctors Association of NSW (Inc)

WHAL welcomes this opportunity to make a submission to the Inquiry into the health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

Our detailed submission addressing the Inquiry's Terms of Reference is outlined in the following sections. The key points to be highlighted to the Legislative Council are summarised below.

SUMMARY OF ISSUES

Western NSW Population

- The Western NSW PHN population of 309,250 is dispersed across more than half the land mass of NSW
- Approximately 11% of the population identify as Aboriginal and Torres Strait Islander
- Average age is 40 years compared to 32 years for NSW
- Residents of WNSW PHN have the lowest life expectancy of any NSW PHN (with Aboriginal people having a lower life expectancy than non-Aboriginal people)
- There are high levels of socio-economic disadvantage, particularly in Far West and North West NSW
- Residents of Western NSW have poorer health outcomes than residents of NSW as a whole. They experience higher rates of preventable hospitalisations and higher prevalence of chronic disease risk factors.

Access to health and hospital services is at crisis point in many small communities

- GPs are central to primary health care but there is limited and variable access to GP services in Western NSW. All of the WNSW PHN, with the exception of Parkes, is identified as a Distribution Priority Area recognising shortage of the GP workforce.
- Where patients have difficulty accessing GPs in their practice, they seek services at the hospital Emergency Department. The WNSW PHN has the highest rates of in-hours and out of hours ED attendances of any PHN nationally.
- There are 41 small towns in Western and Far West NSW that are at risk of not having a practising GP in 10 years, with nine of these at short-medium term risk. Of concern, security of access to quality general practice and primary care is most at risk in communities where there are the greatest health disparities.
- New service models and funding models are required to sustain primary care, acute care and emergency care in small rural towns. The one size fits all general practice fee-for-service and VMO model is no longer fit for purpose where populations are in decline and experience higher disadvantage.

Greater effort is needed to improve coordinated and integrated care

- The Western NSW population is serviced by an array of services funded by State and Commonwealth governments creating a complex, often uncoordinated and fragmented care environment. There is a need for regional, sub-regional and community level joined-up planning, service and workforce design for sustainable integrated care.

- In a co-design process in Far West NSW, NSW eHealth identified four options to improve Heath Information Exchange between NSW Health and non-NSW Health Providers. It is now time to progress a tender process to enable the development of a solution for two-way sharing of clinical information in real time. This will provide immediate benefits for palliative care in the Western and Far West LHDs and build on the shared care model in place.

Addressing staffing challenges to maintain hospital services

- NSW Health or specific LHDs have sought to draw on health workforce staffing models from other jurisdictions to meet service delivery challenges. However, their implementation has not included the full suite of strategies for comparable effect. Key examples are nurse-led models of care in rural hospitals and adequate resourcing to support Rural (Medical) Generalist training.
- There is a disconnect between the Ministry of Health policy to develop a Rural (Medical) Generalist workforce to provide medical staffing to rural hospitals and the action of Western NSW LHD to reduce VMO positions. This disconnect is further reflected where LHDs are not proactively pursuing the maintenance of procedural services in rural hospitals.
- The NSW Health Education and Training Institute (HETI) has an extensive range of educational and research resources available to health professionals, medical practitioners and junior doctors employed by the LHDs. In recognition of the challenges faced by rural and remote nurses, allied health, GP Registrars and Aboriginal and Torres Strait Islander Health Workers and Practitioners working in private and non-Government organisations, consideration could be given to providing access to these practitioners for professional development and maintaining rural training and career pathways.

Collaborations between the WNSW PHN, Far West and Western NSW LHDs to improve access and availability of palliative care in rural, regional and remote NSW

- The WNSW PHN, Far West and Western NSW LHDs have worked diligently together to develop and implement a framework to optimise palliative care in rural, regional and remote NSW. This includes an electronic resource to support and improve their clinical practice. However, work to progress the Shared Locality Record component has been challenged by the inoperability of health information systems between general practice and NSW Health. While eHealth NSW is developing a single digital record to be used across all LHDs, the pilot does not include interoperability with the predominant GP software systems (Best Practice and Medical Director).

RECOMMENDATIONS

TERMS OF REFERENCE		RECOMMENDATION
1(a), 1(b)	***Health outcomes for people residing in the WNSW PHN***	**Recommendation 1.** That formal agreements be made between PHNs and LHD to work together on Regional Health Priorities as identified by PHN's regional health needs assessment, annual sharing of financial and operational plan information between LHDs and PHN Community Health and Primary Health activities by sub-region; a commitment to working towards agreed and shared target outcomes in line with the quadruple aim.
1(c)	***Access to health and hospital services in rural, regional and remote NSW***	**Recommendation 2.** That formal agreements be made between the WNSWPHN, WNSW LHD and Far West LHD to work together on a new shared service and funding model that addresses the urgent problem identified in 41 towns in Western and Far West regions where approximately a quarter of the population at risk of not having a practising GP over the next 10-15 years, and making primary care, acute care and emergency care sustainable.
1(d)	***Patient experience, wait times and quality of care in rural, regional and remote NSW***	**Recommendation 3:** That formal agreements made between PHNs and LHDs to regularly share LHD and PHN health data to inform population health and service planning.
		Recommendation 4: NSW Health to commit to resourcing Health Pathways in all regions.
		Recommendation 5. NSW Health progress a tender process for a solution that facilitates the two-way sharing of clinical information in real time between hospital, community health, general practice and Aboriginal Community Controlled Health Organisations
1(f)	***New service models and funding models are required to sustain primary care, acute care and emergency care in small rural towns***	**See recommendation 2 above.**
1(g)	***Strategies to address staffing challenges need to be comprehensive***	**Recommendation 6:** NSW Health to amend its Rural Medical Generalist Training Program (RTGP) to incorporate the missing critical elements of quarantined and adequate number of GP intern positions in the regions; adequate resourcing for program support; regionally focussed workforce and training plans; and industry recognition of the RG qualification.
		Recommendation 7: NSW Health and LHDs maintain procedural in rural hospitals, i.e. obstetric, anaesthetics and emergency services including birthing services, demonstrating alignment of policy at a state-level and regional level for development and maintenance of the Rural Medical Generalist workforce.

TERMS OF REFERENCE		RECOMMENDATION
		Recommendation 8: NSW Health to build the capability of rural health professionals by sharing educational and research resources of the NSW Health Education and Training Institute (HETI) with private, non-government and Aboriginal Community Controlled Health services.
1(j)	***Collaborations between the WNSW PHN, Far West and Western NSW LHD to improve access and availability of palliative care in rural, regional and remote NSW***	**Recommendation 9:** NSW Health to support the implementation of the Shared Locality Record with interoperability record with GP software systems

2 RESPONSE TO TERMS OF REFERENCE

2.1 OVERVIEW OF THE WNSW PHN POPULATION

In 2016, the estimated resident population of the WNSW PHN was 309,250.

- **While this represents 4% of the NSW population, it is dispersed over a land area of nearly 55% of NSW.**
- **More than one third of the region's Local Government Areas (LGAs) are classified remote or very remote** under the Modified Monash Model (MMM).
- **About half the population live in the four regional centres** of Bathurst, Orange, Dubbo and Broken Hill.
- **Lowest population densities are in the Far West and North West LGAs**.
- **The age structure is bi-modal with the majority of the population aged 0-14 years or 50-69 years**, compared with NSW where the largest proportion of the population occupies the 25-44 years age group.
- The average age of the **WNSW PHN population is older than NSW** (40 years compared with 32 years)
- Between 2016 and 2036 the **population is expected to increase by 6% compared with 20% for NSW.** However, there is sub-regional variation with **LGAs in the Far West (Wentworth, Balranald and Broken Hill) predicted to decline by up to 10%**.
- **WNSW PHN has a higher proportion of Aboriginal people residing in the region compared with NSW as a whole**. At the 2016 Census 31,455 Aboriginal people resided in the WNSW PHN (11% of the population), compared with 2.9% for NSW. In the remote LGAs Aboriginal people make up a higher proportion of the population i.e. Brewarrina (61%), Central Darling (40%), Bourke (32%), Coonamble (30%) and Walgett (29%).
- **Residents of the WNSW PHN experience higher levels of socioeconomic disadvantage.** The Social Economic Index for Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD) for the WNSW PHN is 954, lower than the Australian score of 1000.
    - In 2016, **more than a third (37%) of the WNSW PHN LGAs were ranked in the two lowest deciles** i.e. Far West and North West NSW.

2.2 HEALTH OUTCOMES FOR PEOPLE RESIDING IN THE WNSW PHN

[Terms of Reference 1(a), 1(b)]

Regional and sub-regional disparities in access to primary care, acute care and specialist services, coupled with socio-economic (dis)advantage and health risk factor behaviours result in lower life expectancy at birth for WNSWPHN residents (80.3 years compared with 83.1 years for NSW) and poorer health outcomes and higher rates of hospitalisation for residents in the more rural and remote communities of the WNSW PHN (Source: WNSW PHN Health Needs Assessment 2019-2022).

- **The WNSW PHN region has higher risk factors compared to the rest of NSW.** In Western NSW, 22.9% of people over 16 years smoke compared with 15% for NSW; 26.5% of people over 16 years are obese, compared with 21% for NSW; 37.2% of people over 16 years consume alcohol at levels of long-term risk, compared with 31.1% for NSW.

- **Potentially avoidable deaths for WNSW PHN residents are 43% higher than NSW**. For the five year period 2011-2016, 151.9 compared to 106.4 per 100,000 respectively. There was sub-regional variation with rates highest in Walgett, Broken Hill and Brewarrina LGAs.
- **Potentially preventable hospitalisation rates are on average 16% higher than NSW.** For the five-year period 2012-2017, 2460.6 PPH compared to 2118.2 per 100,000 respectively. Highest rates occurred in the North West i.e. Walgett, Bourke, Brewarrina and Bourke.
    - In 2015-2016, Potentially Preventable Hospitalisations for chronic conditions in the WNSW PHN were slightly higher than the national average. However, the Average length of stay (ALOS) was 5.5 days – the highest of any PHN, indicating greater severity. PPH for chronic conditions were highest in Bourke, Cobar, Coonamble, Broken Hill and Far West.
- **Hospitalisations for diabetes was 41% higher in WNSW PHN compared with NSW for 2012-2017.** Average Hospitalisation rates for diabetes increased with rurality and remoteness with Broken Hill, Bourke, Brewarrina and Unincorporated Far West reporting highest rates.
- **Respiratory disease is a leading cause of death and mortality rates for respiratory disease in WNSW PHN is 50% higher than NSW** (73.6 compared to 49.1 per 100,000 in 2016) and COPD annual average mortality rates are 55% higher than NSW (2010 to 2015).
- **CVD was the leading cause of death in WNSW PHN residents in 2016 accounting for 28% of deaths.**
    - Between 2011 and 2016, the average rate of CVD mortality was 21% higher than for NSW as a whole. Again, there is sub-regional variation with higher rates of CVD mortality in the Western Plains LGA (31% higher than NSW) and in Walgett, Coonamble, Gilgandra and Cobar. Hospitalisation for CVD in the WNSW PHN was 17% higher than NSW
- **Cancer is the second leading cause of death in WNSW PHN in 2016, and the average mortality rate was the highest of all NSW PHNs between in the five year period 2009-2013.**
    - WNSW PHN has the third highest incidence of cervical cancer of all PHNs nationally, and slightly lower screening rates (53% compared with 55% nationally).
- **Suicide rates were 20% higher in WNSW PHN compared with NSW over the 2012 to 2016 period.**
    - Intentional self-harm for WNSW PHN males aged 15 to 24 years was 24% higher than for NSW (2012-2017).
- **Hospitalisations for anxiety and stress disorders were 80% higher in the WNSW PHN than the national average in 2015-2016, and overnight hospitalisations for depressive episodes was 42%.**
    - Over the five-year period 2011 to 2016, rates of emergency presentations for mental health problems in WNSW PHN residents increased by 70%. Within the PHN there is sub-regional variation with Walgett, Western Plains (Dubbo), Warrumbungle, Cobar, Cowra and Warren reporting highest increases.
- **With respect to Alcohol and Other Drugs (AOD), the WNSW PHN experiences the highest annual mortality rate of any NSW PHN and is 41% higher than NSW.** Highest alcohol attributed deaths occur in the North West (Bourke, Brewarrina, Bogan, Coonamble, Walgett and Warren LGAs). Not surprising, AOD-related presentations to ED were 8% higher than NSW (2011-2015) and ED presentations increased by 20% in 2015 compared to 2011.

- **WNSW PHN region has seven of the ten worst LGAs in NSW in terms of Domestic Violence** (BOSCAR - NSW Recorded Crime Statistics July 2019 to June 2020)
- **The Aboriginal population experience worse health outcomes than non-Aboriginal people in the WNSW PHN**. Of note:
  - The annual average rate of PPH of Aboriginal residents is 3 times that of non-Aboriginal residents
  - The average annual perinatal mortality rate for Aboriginal children (0-4 years) was 45% higher than for non-Aboriginal children over the 2009 to 2013 period.
  - Smoking during pregnancy occurs in 53% of Aboriginal mother compared with 17% of non-Aboriginal mothers, and 12% of babies born to Aboriginal mothers were of low birth weight compared to 6% for non-Aboriginal mothers (2012-2016 period).
  - Hospitalisations due to mental disorder were 86% higher for Aboriginal people in the WNSW PHN compared with the non-Aboriginal population (2016-2017).

Recommendation 1. That formal agreements be made between PHNs and LHD to work together on Regional Health Priorities as identified by PHN's regional health needs assessment, annual sharing of financial and operational plan information between LHDs and PHN Community Health and Primary Health activities by sub-region; a commitment to working towards agreed and shared target outcomes in line with the quadruple aim.

2.3 ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NSW

[Terms of Reference 1(c)]

Access to health care can be conceptualised as the potential ease with which consumers can obtain health care, and is a complex and multidimensional concept. Disaggregation of the concept of access into the dimensions of access outlined below, allows policy makers and health service organisations identify key questions to be addressed in the planning and delivery of services to ensure optimal access to health care for rural, remote and regional Australians.

Dimensions of Access.[1]

	Definition: The fit between	
Access dimensions	**Health system characteristics**	**Population characteristics**
Availability	The volume and type of services	The volume and type the population needs
Geography	Proximity of providers to consumers	The ease with which the population can transcend this space
Affordability	The direct and indirect costs of securing health care	The consumer's ability to meet the direct and indirect costs of health care

[1] Russell DJ, Humphreys JS, Ward B, Chisholm M, Buykx P, McGrail MN, Wakerman J. (2013). Helping policy-makers address rural health access problems. *Aust. J Rural Health,* 21: 61-71.

Accommodation	The manner in which the supply resources are organised	The consumer's ability to contact, gain entry to and navigate the health system
Timeliness	The time until health care can be provided	The urgency of the need for health care
Acceptability	The provider's attitudes and beliefs about health and personal characteristics of consumers (e.g. age, gender, ethnicity, religion)	The consumer's attitudes and beliefs about health and personal and practice characteristics of providers
Awareness	The communication of health and health systems information to consumers	The consumer's understanding of their health needs and knowledge of how to have these needs met

The WNSW PHN Health Needs Assessment (2019-2022) drew on published data sources and extensive consultation processes to identify issues impacting on access to health services for residents of the regions within the footprint of the Western NSW and Far West LHDs.

2.3.1 Limited and variable access to GP services

In rural and remote NSW, GPs are the cornerstone of the primary care and secondary care health service system. General Practitioners (GPs) provide health care to people across the lifespan and are central to early identification and management of chronic and complex conditions and mental health problems in conjunction with allied health, specialised nurses and/or medical specialists. GPs in rural and remote communities work as Visiting Medical Officers (VMOs) to rural hospitals providing emergency care, acute and inpatient care. In District Hospitals, GP VMOs may provide a range of procedural services including obstetrics, anaesthetics and surgery.

However, at November 2020, **all of the WNSW PHN is identified as a Distribution Priority Area (DPA)[2] with the exception of Parkes**.[3]

2.3.2 The number of GPs practising in the WNSW PHN region is less than both the state and national averages.

In 2017, the GP FTE for WNSW PHN was 7.4 per 10,000 compared to 8.1 per 10,000 for NSW and 7.8 per 10,000 population nationally. Distribution across the region varied from 8.6 per 10,000 in the South-Eastern area, to 3.37 per 10,000 in the North West, and 2.8 per 10,000 in the far south west.

As a result, in 2016-2017:

- The number of GP attendances per person per year, age-standardised, was 10% lower than the national rate i.e. 5.3 compared to 5.9, respectively
- The number of after-hours GP attendances per person per year, age-standardised was almost 3 times lower that for Australia, 0.18 compared to 0.49, respectively. This was the lowest of any PHN nationally.

[2] Distribution Priority Area (DPA) identifies areas where people do not have enough access to GPs to meet the needs of the community. DPA takes into account gender, age demographics and socio-economic status of patients living in an area. https://www.health.gov.au/health-workforce/health-workforce-classifications/distribution-priority-area

[3] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

2.3.3 Where patients have difficulty in accessing GPs in their practices, they seek services at the hospital Emergency Department.

This is evident in Western NSW where the PHN has the highest rates of in-hours and out-of-hours ED attendances of any PHN nationally (227 and 206 per 1,000 people, respectively) with a third of all low acuity ED presentations occurring between the hours of 9 am and 1 pm (2015-2018).

However, in many towns where the GP(s) is also the VMO this does not reduce their workload, but rather shifts the provision of care from their practice (billed through Medicare +/- patient co-payment) to the hospital (billed to NSW Health/LHD).

2.3.4 Maintaining workforce in small towns presents significant challenges for provision of primary, acute and emergency care

Outside the four regional centres of Bathurst, Dubbo, Orange and Broken Hill, the WNSW PHN region has 46 small towns ranging in size from Parkes with a population of 11,000 to Tullamore with just over 200.

The WNSW PHN has identified **41 towns in Western and Far West regions (approximately a quarter of the population) at risk of not having a practising GP over the next 10-15 years**. The contributing factors include:

- Ageing GP workforce, with more than half the GPs in small towns over 55 years and likely to retire in 10-15 years
- One third of practices are operated by solo practitioners
- Difficulty in recruiting and retaining practice nurses, Aboriginal Health Workers, allied health professionals and administration staff
- Financial sustainability of the practice, with about 60% of surveyed practices describing their practice as being only just viable reflective of the demographics of these communities and the tension with the fee-for service
- Generational changes with new GPs not wishing to own and manage a practice and seeking better work-life balance than the doctors they are replacing.

2.3.5 Security of access to quality general practice and primary care is most at risk in communities where there are significant health disparities.

Sustainability of general practice is a complex concept. There needs to be sufficient "business" for the practice to be financially viable under the current fee for service model (through Medicare and patient co-payment) but this is challenged in communities where there is a small and financially disadvantaged population evident in many small communities in WNSW PHN. A recent analysis identified nine general practice locations had a population (at LGA level) of < 800 per GP. Alternatively, communities can have a high ratio of patients to providers and while this creates demand (and is good for business), the workload is unsustainable particularly in towns where there are solo practitioners. Eleven (11) general practice locations had a ratio of >1,600 patients per GP.[4]

[4] Australian Healthcare and Hospitals Association (2019). The vulnerability of small towns and communities to secure access to quality primary care.

The AHHA study commissioned by WNSW PHN identified a series of characteristics to quantify the strength and vulnerabilities of community's to effectively support local general practice and primary care services.[5] The resultant risk assessment tool identified nine (9) locations that were vulnerable on more than 4 of the 8 risk measures. These communities are Balranald, Bourke, Brewarrina, Cobar, Collarenebri, Coonamble, Lightning Ridge, Walgett and Warren.

The majority of these vulnerable communities report the highest rates of potentially avoidable deaths, potentially preventable hospitalisations, higher rates of CVD mortality, higher rates of hospitalisation for diabetes, higher rates of emergency presentations for mental health problems, higher rates of Alcohol-attributed deaths. The Aboriginal population of four of these communities is between 29% and 61% of the total population.

Recommendation 2. That formal agreements be made between the WNSWPHN, WNSW LHD and Far West LHD to work together on a primary health collaborative service and funding model that addresses the urgent problem identified in 41 towns in Western and Far West regions where approximately a quarter of the population at risk of not having a practising GP over the next 10-15 years, and making primary care, acute care and emergency care sustainable.

2.4 PATIENT EXPERIENCE, WAIT TIMES AND QUALITY OF CARE IN RURAL, REGIONAL AND REMOTE NSW

[Terms of Reference 1(d)]

2.4.1 Uncoordinated and fragmented care

The Western NSW population is serviced by array of services funded by State and Commonwealth governments creating a complex, often uncoordinated and fragmented care environment. There is a need for regional, sub-regional and community level joined up planning, service and workforce design to progress integrated care models.

The WNSW PHN region is serviced by two LHDs, 110 general practices, 20 Aboriginal Community Controlled Health Organisations (ACCHOs), and private allied health practitioners and multiple non-government organisations providing a range of mental health, chronic care, aged care and disability services.

An ongoing challenge is the extent to which agencies and practitioners collaborate and coordinate care around the patient, particularly where the agencies and providers are funded by various mechanisms (many of which are time limited) and have different strategic aims and reporting requirements. This is particularly problematic for patients with complex conditions such as chronic diseases, mental health, and people with a disability that are seeking services and supports from general practice and primary care, public health services (hospital and community-based) and social supports.

The four year WNSW Integrated Care Strategy was developed with the intent of developing and testing integrated care models. The evaluation of the Integrated Care Strategy has demonstrated:

[5] Ibid

- Positive health outcomes for enrolled patients where ***the integrated care navigator/ case conferencing model based in general practice*** has promoted horizontal integration across health and social care services, and vertical integration with involvement of acute care and specialist clinicians.
- Reduced the number and cost of hospitalisations and ED presentations in the Chronic-Disease management sites
- Reduced the rising trend for Medicare-billable services for enrolled patients.

Local leadership, appropriate governance arrangements and commitment to inter-professional learning and care delivery were key factors positively influencing professional and organisational integration. [6] However, for integrated care to be sustained there needs to be proportionate investment by partners and joint accountability for priority setting, staff effort and resource allocation.

Recommendation 3: That formal agreements be made between PHNs and LHDs to regularly share LHD and PHN health data to inform population health and service planning.

2.4.2 Western NSW is the only region where NSW Health has not invested in HealthPathways.

HealthPathways is an evidence based online health information portal for GPs, to be used at the point of care. It provides clinical guidance and referral pathways that are locally agreed between primary and secondary care. Of the 11 NSW regions, 10 regions (except Western NSW) have locally invested and driven the development of pathways that support local community needs. Each region is funded and governed through local processes.

Opportunities to progress electronic referrals through innovations such as the SeNT e-referral system is not available to GPs and emergency departments, hospital outpatient and mental health services in Western NSW as it is in other LHDs that have invested in HealthPatways. In the Hunter New England region, the HNECC PHN, HNE HealthPathways Team and Hunter New England Health are developing a 'whole of health system' e-referral solution for GPs, specialists and other primary care providers.

During the COVID 19 pandemic, NSW Health enabled access to the COVID HealthPathways for WNSW PHN, Western NSW and Far West LHDs but this does not extend to other clinical areas. NSW Health is currently undergoing a value based proposition to identify a more equitable approach to supporting HealthPathways for NSW. This is key in Western NSW to improve hospital service utilization, reduce inappropriate referrals, improve GP management and reduce ED attendances.

Recommendation 4: NSW Health to commit to resourcing Health Pathways in all regions.

2.4.3 Time to act to improve Health Information Exchange for better health outcomes

People access health care in various settings and as a result their clinical information sits in various information systems or paper-based records which means that:

- Patients have to re-tell their story and medical history to multiple providers
- There can be a delay and higher cost of care due to no information available from different care settings, and potential for duplication of pathology and other diagnostic tests

[6] Edwards K., Kirby S., Yu S., van Gool K., Hall J., Harris-Roxas B. *Evaluation of the Western NSW Integrated Care Project: Final Report,* Centre for Primary Health care and Equity, University of New South Wales. February 2019.

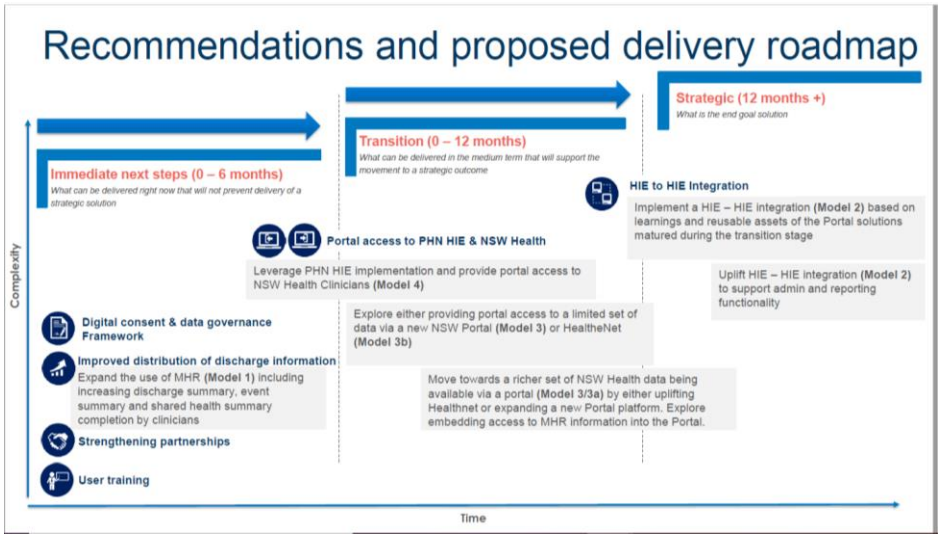
- Clinical risk is heightened where relevant information is not available at the point of care
- Lack of information sharing impacts on continuity of care as patients move between providers
- There is risk to data quality and integrity with manual upload of data to digital records or transcription error.

In June 2020, NSW eHealth convened a series of workshops in the Far West to develop solutions to improve health information exchange (HIE) between public, private and Aboriginal Community Controlled providers operating across primary and acute care.

This process identified four "stand out" digital information sharing models and a timeline for delivery (Diagram 1). The models include:

- Model 1: Expanding the use of My Heath Record (MHR)
- Model 3 and 3a: Portal Access to NSW Health for non-NSW Health Providers
- Model 4: Portal Access to PHN HIE i.e. the PHN maintains a HIE that interfaces with non- NSW Health providers in their boundary (iRAD), and multiple PHNs may agree to use this
- Model 2: HIE to HIE integration i.e. PHN HIE integration with NSW Health HIE.

Diagram 1



Recommendation 5. NSW Health progress a tender process for a solution that facilitates the two-way sharing of clinical information in real time between hospital, community health, general practice and Aboriginal Community Controlled Health Organisations.

2.5 NEW SERVICE MODELS AND FUNDING MODELS ARE REQUIRED TO SUSTAIN PRIMARY CARE, ACUTE CARE AND EMERGENCY CARE IN SMALL RURAL TOWNS.

[Terms of Reference 1(f)]

NSW Health is reliant on GPs working in private practice to provide VMO services to rural hospitals and multi-purpose health services. However, this one size fits all approach is no longer fit for purpose for many small rural communities in Western NSW where the viability of the fee-for-service general practice model is challenged by the declining population and low socio-economic status, when the new generation of doctors are not willing to invest in and manage practices and are not willing to work

in locations where the on-call requirements are unsustainable. In Western NSW market failure is rife and several corporate and private providers have failed to create a sustainable business model to carry on delivering services in the region in recent years.[7]

There are 41 small towns in Western and Far West NSW that are at risk of NOT having a GP within 10 years. Nine of these towns are highly vulnerable in the short to medium term. These towns include: Balranald, Bourke, Brewarrina, Cobar, Collarenebri, Coonamble, Lightning Ridge, Walgett and Warren.[8] Without intervention, there will be no GPs that are willing to take the place of those that leave and people will have limited access to essential primary care services. Hospital admissions will increase as will the burden on the health system more broadly.

New funding and service models are needed for small towns that bring together and align investment by NSW Health and the Commonwealth to not only stabilise GP and hospital services but also strengthen the recruitment and retention of the broader nursing, allied health and Aboriginal Health Practitioner workforce so that residents have access to sustainable and culturally safe primary care, acute care and emergency care.

SEE RECOMMENDATION 2.

2.6 STRATEGIES TO ADDRESS STAFFING CHALLENGES NEED TO BE COMPREHENSIVE

[Terms of Reference 1(g)]

There are examples where NSW Health or specific LHDs have sought to draw on staffing models and arrangements from other jurisdictions to meet service challenges. However, their implementation has not included the full suite of strategies required for comparable effect. Two examples are provided.

Nurse-led models of care in rural hospitals

The Western NSW LHD has sought to use a nurse-led model to maintain rural hospital services supported by a remote telehealth medical support this has presented significant patient safety issues. While nurse-led clinics with remote medical support are in place in locations in the Northern Territory and Western Queensland, there are fundamental differences to the approach used in Western NSW. Key differences include:

- The population of many of the towns in which the nurse-led models have been implemented in Western NSW are of a size that supports/requires full-time general practitioner presence. In comparison the communities in Western Qld are usually 200-300, and in the NT may range from several hundred to about 1,000 but in these larger communities (e.g. Lajamanu, Kalkarindji) there is a doctor providing primary care services 4-5 days a week.
- The small hospitals/ health clinics in the NT and Western Queensland are staffed by nurses with Remote Area Nursing endorsement equipped to work in remote and isolated settings

[7] AMA 2019, Position statement: Easy Entry, Gracious Exit Model for Provision of medical services in small rural and remote towns.
https://ama.com.au/sites/default/files/documents/Entry_Gracious_Exit_Model_for_Provision_of_Medical_Services_in_Small_Rural_and_Remote_Towns_2019_1.pdf

[8] Australian Healthcare and Hospitals Association. 2019. The vulnerability of small towns and commuiti4s to secure access to quality primary care.

- The doctors providing the remote service have a good knowledge of the community and local staff. These doctors usually provide visiting medical services to the community and often know the patient, know the capability and capacity of the local Remote Area Nurses and clinical capability of the small hospital/clinic
- Clinical protocols are outlined in manuals which the doctors, nurses and Aboriginal Health Practitioners use and have been developed specifically for the context in which the health professionals are practising i.e. CARPA Standard Treatment Manual (NT), the Royal Flying Doctor Primary Clinical Care Manual (Qld).

Rural Generalist workforce

NSW Health introduced the Rural Medical Generalist Training Program (RTGP) in 2013 as a training strategy for junior doctors wishing to pursue a career as a rural general practitioner with an advanced skill providing primary care in a community general practice setting as well as advanced services and/or procedural skills within a rural hospital. Advanced skills available include obstetrics, anaesthetics, emergency medicine, mental health, palliative care, paediatrics. The intention of the program is to develop a workforce to maintain the birthing and specialised services in rural communities hence improving access to care for rural residents.

The NSW RGTP has largely drawn on the highly successful Rural Generalist model that was established in Queensland in 2005 to stabilise emergency and procedural services in smaller hospitals/towns in rural and remote Queensland.

However, the NSW model has failed to implement critical elements of the Qld model including:

- Quarantined and adequate number of internships in rural and regional hospitals to enable medical graduates to transition to a rural training pathway at the completion of their university training (rather than an initial internship in a metropolitan location where there is the risk of leakage from the rural pathway)
- Adequate resourcing of program staff and Medical mentors to provide vocational guidance and support trainees to plan and execute their training pathway
- A regionally focused workforce and training plan that ensures that RG trainees are pursuing advanced skills training in a discipline that is required in preferred or identified location (i.e. training in a skill with a known job destination)
- Industrial recognition of the RG qualification – in Qld this is equivalent to Staff Specialist.

While NSW maintains the VMO model for GPs providing procedural services to rural hospitals under the NSW RDA settlement package, there is no financial recognition/ differentiation of the Advanced Skills Training in mental health, paediatric and palliative care – all of which are priorities in rural areas where access to psychiatrists, paediatricians and palliative care specialists is very limited. Therefore, NSW Health should develop a mechanism to remunerate GPs/Rural Generalists with Advanced Skills Training in mental health, paediatrics and palliative care as the key providers of specialised care in rural and remote communities.

Recommendation 6: NSW Health to amend its Rural Medical Generalist Training Program (RTGP) to incorporate the missing critical elements of quarantined and adequate number of GP intern positions in the regions; adequate resourcing for program support; regionally focussed workforce and training plans; and industry recognition of the RG qualification.

2.6.1 Proactive maintenance of procedural services in rural communities

There is a disconnect between the NSW Ministry of Health policy to develop a Rural Generalist workforce to staff rural hospitals and the action of the Western NSW LHD to reduce VMO positions in rural hospitals.

Given the investment in Rural Generalism by the Ministry, it is imperative that NSW Health, through the regional LHDs, is proactive in maintaining obstetric, anaesthetics and emergency services in rural hospitals, demonstrating alignment of policy at a state-level and regional level. Importantly, these procedural services ensure rural residents have timely access to care as close to home as possible. Furthermore, maintaining birthing services in rural hospitals reduces disruption for families where mothers need to re-locate to regional towns for several weeks prior to the expected delivery. However, time is of the essence as the NSW procedural GP workforce is in significant decline, with an estimated 33% of GP Proceduralists moving toward retirement by 2025.[9]

Maintaining procedural services in rural hospitals requires the regional LHDs to:

- Proactively recruit and retain sufficient numbers of midwifery and theatre nurses to ensure continuity of birthing and theatre rosters
- Support visiting medical specialists to undertake surgical lists in rural hospitals so that GP anaesthetists (RG anaesthetists) can maintain their skills
- Ensure rural hospitals have adequate and appropriate equipment to support the provision of surgical, obstetrics and emergency services
- Offer opportunities and financial support to Rural Generalists/ GP VMOs to undertake clinical placements in regional hospitals to undertake procedures to maintain clinical skills (where higher caseload is necessary) and to establish/maintain clinical networks with Medical Specialists within their referral network.

Recommendation 7: NSW Health and LHDs maintain procedural services in rural hospitals, i.e. obstetric, anaesthetics and emergency services including birthing services, demonstrating alignment of policy at a state-level and regional level for development and maintenance of the Rural Medical Generalist workforce.

2.6.2 Building the capability of rural health professionals by sharing educational and research resources

The NSW Health Education and Training Institute (HETI) has a suite of educational modules on extensive range of topics available to employees of NSW Health. Given the challenges of rural and remote health professionals working in the private, not-for profit and Aboriginal Community

[9] NSW Rural Doctors Network. *2018-2019 Primary Health Workforce Needs Assessment. Summary Report.*

Controlled health sector to access professional development, NSW Health should consider extending access to education resources to practitioners external to NSW Health.

HETI maintains research databases for medical practitioners and doctors in training employed by the LHD. However, access to these research resources is withdrawn when registrars commence GP training. NSW Health could demonstrate its commitment to progressing and maintaining rural medical training pathways by allowing access to research resources for GP registrars working in rural and remote general practices and Aboriginal Community Controlled Health Services.

Recommendation 8: NSW Health to build the capability of rural health professionals by sharing educational and research resources of the NSW Health Education and Training Institute (HETI) with private, non-government and Aboriginal Community Controlled Health services.

2.7 Collaborations between the WNSW PHN, Far West and Western NSW LHD to improve access and availability of palliative care in rural, regional and remote NSW

[Terms of Reference 1(j)]

The Shared Health and Advance care Record for End of life choices project (SHARE) is funded by the Commonwealth Department of Health under the Primary Health Networks Greater Choice for At Home Palliative Care measure.

The SHARE project builds on earlier work done by the Far West Local Health Districts Specialist Palliative Care team and the Broken Hill University Department of Rural Health. Dr Sarah Wenham, the Specialist Palliative Care Physician, in the first phase, developed the Model of care and Framework for use in residential aged care facilities at a time when the existing low care facilities were commencing on a new journey of ageing in place and the existing staff didn't have the skills and strengths in regard to dying as a normal process.

The goals of the collaborative SHARE project are to:

- Improve access to the best palliative care at home
- Support palliative care services in primary health and community care
- Make sure people get the right care, at the right time and in the right place to reduce unnecessary hospital visits
- Generate and use data to improve services
- Use technology to provide flexible and responsive care, including after-hours care

To achieve our set goals and move the Far West Palliative Approach Framework forward, the SHARE project has worked towards developing and implementing, the electronic Palliative Approach Framework (ePAF). The ePAF has been designed to build capacity and improve provision of comprehensive, consistent, patient-centred, needs based, high-quality palliative and end of life care for all, irrespective of diagnosis, care location or care provider. The project is being trialled across a number of residential aged care facilities and multipurpose services in the WNSW PHN region in partnership with the Far West and Western NSW LHDs.

The ePAF is made up of 3 major components:

- **The Web Resource Centre** was built and launched in May 2019 and is housed on the WNSW PHN website. This Web Resource Centre holds the electronic Palliative Approach framework and model of care and the documents required by both health care professionals and clients or their carers to access end of life care information in a timely manner. To the end of October 2020, 3,875 unique visitors have visited the site and viewed 6909 pages of information. It is a one stop shop for palliative care information.
- **The Shared Locality Record** is being progressed in partnership with South West Sydney Primary Health Network. Their integrated Real-time Active Data (iRAD)[10] solution delivers an interoperability system that provides relevant clinical information in real-time, giving timely access to key information to improve access to safe, quality palliative care.
- **A Data Dashboard** built using Power BI, a business analytics service, allowing measurement of quality clinical and educational outcomes leading to an improvement in services in pilot sites. The ePAF generated data monitors clinical care using the End of Life Minimum Universal Tool (EMU). EMU is consistent KPIs and data collection items that are outcome focused for palliative care, enabling tracking and benchmarking of patterns of care and informing future service development.

The ePAF aims to achieve improvements in clinical outcomes for patients, workforce skills and communication between RACFs, general practice and specialist palliative care services. The translational impact begins by changing the local policy and practice of sites and services through the adoption of a palliative approach through the Framework and optimising care to context.

While the ePAF resource is being used by clinicians to support and improve their clinical practice, work to progress the Shared Locality Record component has been challenged by the inoperability of health information systems between general practice and NSW Health. While eHealth NSW is developing a single digital record to be used across all LHDs, the pilot does not include interoperability with the predominant GP software systems (Best Practice and Medical Director).

To support the implementation of the Shared Locality Record as a component of ePAF, the WNSW PHN has purchased Best Practice for the Far West Specialist Palliative Care Service so that its data can be uploaded to iRAD. This will enable GPs, Specialist Palliative Care Services and Ambulance access patient records (with consent) to update clinical information and view Advanced Care Directives in real time.

However, the localised "go-around solution" highlights the need for immediacy of national and state level action to progress digital solutions Health Information Exchange.

Recommendation 9: NSW Health to support the implementation of the Shared Locality Record with interoperability record with GP software systems.

[10] The iRAD is a cloud-based interoperability solution that is Electronic Medical Record (EMR) agnostic, enabling providers to access a complete view of their patients' health information. The tools have been designed to integrate and exchange patient information seamlessly across the healthcare continuum, including My Health Record.