ACI NSW Agency for Clinical Innovation

Key themes arising from ACI Rural Health Network survey conducted February 2013

The purpose of the survey was to seek the following from Rural Health Network members (clinicians, managers, rural health workers, Non Government Organisations, private practitioners, Department of Education, NSW Ambulance, consumers, Aboriginal Medical Services, Residential Aged Care Facilities). 300 surveys were distributed, 150 were returned representing a 50% response rate.

1. Top three priority issues which impact most on the delivery of high quality services in rural communities?
2. Outstanding initiatives /programs which address the issues identified?

The key themes, arising from collated surveys include:

- Workforce – recruitment and retention of staff with generalist skills
- Skills acquisition and maintaining credentials
- Access to Specialty services
- Co-ordination of care and reducing silos – one patient one journey
- Transport
- IT & Infrastructure

THEME	ISSUES IDENTIFIED	INNOVATIVE SOLUTIONS
Workforce – recruitment and retention of appropriate generalist skills	• Streamline Recruitment Process - too long and positions are left vacant • Ageing health workforce and historical practices and workplace culture – “still refer to out-dated methods in treatment and not willing to embrace change” • Unfilled vacancies – freeze on filling positions (particularly Allied Health which are frequently contracts, not permanent). “Clinical staff are performing clerical/ administrative functions which reduce time for direct patient care”. • Increased use of overseas trained doctors and agency nurses who are unfamiliar with rural environment, referral patterns, can lead to knowledge and communication issues • High use of locums (“no orientation, no handover, no	• ‘Grow your own’ workforce – programs that allow clinicians to gain skills while living and working near family eg “Online University education for nurses, EN/RN Transition Program, Graduate certificates” • Student led service provision eg Broken Hill program where students assist in the hospital through clinical supervisors • Proposed model that allows school age people to commence nursing

	mentoring – given a folder to read. Local GPs (GP/VMO) are stretched to capacity, very costly”) • Implementing statewide policies in a rural context – eg “Nurse : Patient ratios or flexible work hours require the pool of nurses to draw from” • No succession planning eg positions not backfilled for annual leave and no opportunity for local professional growth	studies as part of the HSC curriculum • University Departments of Rural Health and Rural Clinical Schools • RANZCOG include rural exposure in Fellowship Training • HNE Proposal submitted for Rural Nursing Traineeship – “on the job experience alongside a qualified RN; 3 P/T positions rotating through 3 local hospitals” • Succession planning in some areas – reduced hours for older clinicians
Skills acquisition and maintaining credentials	• **Maintaining credentials and competencies** Example – Midwives require 450 hrs clinical obstetric hours to maintain accreditation, “unrealistic in small rural facilities – Midwives are not renewing their registration and limiting service provision” • **With increased focus on Out of Hosp Care, there has been no resource enhancement (CNC and Nurse Educator positions) for Community Health / Primary Health Care where changing expectations are rapidly occurring** eg Early discharge policy sees “ patients discharged sicker and quicker” yet there is no education to support ‘sub-acute skills for rural generalists • Rural workforce are Generalists dealing with specialty conditions “everything to everyone, all roles tied into one” impacts on retention – more educational support required, yet fewer educators spread over multiple sites & much time lost in travel • Wide variation in skills and knowledge in very small teams – “no capacity to flex up from other departments when busy”	• Specialist clinical support groups for generalists • Statewide Essentials of Care, FLEC, Connecting Care, Chronic Disease Programs • Resources and Clinical Nurse Educator positions have been enhanced in Acute, Sub acute and Rehab areas Eg - Critical Care Cameras in EDs • Statewide Rural Adult Emergency Clinical Guidelines • Qld Health provide education grants for F/T rural and remote nurses • Access to Scholarships • Education seminars held in local areas eg RUSH, NESCC • Some smaller hospitals have a

	• No incentives for rural Advanced Clinical Nurses to take on additional responsibilities of generalists in isolation • New initiatives from pillars welcome, but some sites in MLHD have one nurse who could be the lead in four or five programs – affects sustainability	CMO in house – useful for the ED.
Access to Specialty services	• **Access to Specialty services (Paediatrics, Mental Health AND Young person's mental health outreach, Palliative Care, Renal, Counseling)** • **MBS and IPTAAS tied to Specialist services** Eg – "Baby requires consult with Paediatrician Gastroenterologist before mother can obtain script for appropriate formula ($65 per tin without script). Closest specialist is Westmead, mother not confident driving with sick child" Eg – "Patients requiring an MRI must have a Specialist referral to claim MBS (bulk bill), usually entails 2 trips to Referral centre; one to obtain referral and the other to have the MRI. GP Referral for MRI costs the patient $400" • Lack of access to Paediatric Services – limited Medicare funding • No after hours / weekend Mental Health workers – "aggressive patients present and are kept for hours, often all weekend at small rural facilities". Often no beds available at Mental Health referral centre. Police not always available either after hours. • Long Medical and Public Bulk Billing waiting lists for Medical and Allied Health – lack of access for low income families to obtain MBS supported Health Plans • 'Bed blocking' issues in referral hospitals – eg" it takes many hours and phone calls by senior clinicians to organize acceptance and admission" • Cross Border funding issues	• **Regional Primary Health Program – making Paediatric Allied Health services available in schools (early intervention and to build capacity of families and teachers) eg motor co-ordination programs in schools** • Mobile Clinics – eg Breastscreen • Allied Health Assistants, Aboriginal Health Workers • Increase in Cancer Services / Cardiac Cather labs with appropriately designated diagnostics and clinicians • Multipurpose Services (Governments working together – Centrelink, RTA, Health) • Satellite services for Chemotherapy, Renal, Oncology, Opthalmology, Surgical services • Public / Private partnerships eg Allied Health services • NEAT NEST Incentives – avoiding admissions focus and Health Promotion • Community Paramedic models with telehealth backup for communities where emergency services need to be available but workload is low

	• Telehealth programs can be limited by lack of Specialist clinician supporting outreach • Increasing Private Health Insurance and 'gap' fees (especially with costs for rent / electricity skyrocketing) are impacting on patients accessing services • Decline in procedural facilities – obstetric delivery suites and Operating Theatres means patients have to travel • Compliance difficulties with Aboriginal patients accessing mainstream services • More Men's Health programs in community venues are required (including Mental Health education) • Insufficient community services available locally to support early discharge policies eg Homecare, Home Modifications, Community Aged Care Packages, Transitional Aged Care Programs	
Care Co-ordination - service integration and reducing silos	• Lack of service integration and sharing of information leads to duplication Eg - "between GP, Hospital and external health services" • Absence of patient flow discharge plans from regional referral hosp back to district hosp eg "introduce a patient flow portal" • Make available statewide policies, "instead of 16 LHDs and 16 Policies eg Insertion of Paediatric Nasogastric tube" • Ministry endorsed Guidelines with standing orders for facilities with no doctor (particularly triage 3,4,5) eg- "Paediatric Rural Emergency Clinical Guideline was commenced in 2005, is not yet endorsed " • There are concerns about the proposed National Disability Scheme demanding additional documentation, and the additional administrative burden detracting from clinical work. • Consumers not knowing what is available or where to access information	• Stroke Thrombolytic bypass • Combined inpatient IT systems with chronic / complex pathways between various care providers • Electronic Medical Records
Transport	• **Transport needs must be considered as a major issue in**	• Health funded weekly access bus

	rural communities accessing specialty services • Isolation and low socioeconomic demographics. High cost to patients (petrol, time lost from work) means they rationalize travel eg “this impacts on patients attending the cardiac rehabilitation program three days per week” • Time lost in travel – service providers see fewer patients and access to LHD fleet vehicles is now very competitive • Cost of transporting patients to tertiary centres and between LHDs puts a burden on LHDs • Use of Community Transport is reliant on volunteer drivers – “patients often have to wait hours for their appointment and the inconvenience to the patient and volunteer driver who is usually a retiree, is unnecessary” • Funding for health transport has failed to keep pace with demographic changes. Eg - “renal dialysis requires a round trip of 180km, and there are no buses or taxis. Families meet the cost as the nearest health transport vehicle has to come 100km to get the patient and it is not cost effective”.	for Aboriginal Communities to access AMS, Dentist, Doctor and hospital appointments eg North Coast to Gold Coast North Coast Shuttle • Simulation Bus and simulation centres • Qld have central patient transport dept with an office at each regional hosp – accommodation & travel for patients • RFDS multidisciplinary outreach clinics in remote locations • Specialist Consultations by Telehealth works well in pockets
IT and Infrastructure	• Broadband width problematic in western NSW – unable to support video and audio-visual quality, screen pixilates, still frames or drops out • Poor IT infrastructure. Internet and email access slow and unreliable • LHDs are not on same email system eg GroupWise or Outlook • Telehealth is underutilized • Pockets of low IT literacy within and across Districts • Many facilities are very old and require overdue maintenance	• Videoconference units in most facilities • Nursing Grand Rounds via videoconference • Use of telehealth to provide specialist consults & support clinicians in isolated facilities • Use of webcast education • Health e-tube (MNC LHD) • Argus IT application – communication system between Health Districts and General Practice linked to Chronic Disease management.