NSW MSEC

New South Wales Medical Staff Executive Council (NSW MSEC) Submission to the Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales

December 2020

a. Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales:

The 2019 Australian Institute of Health and Welfare (AHIW) *Rural And Remote Health* report shows that the rate of potentially avoidable deaths in regional areas is 129 per 100,000 people, where in major cities it is only 94 per 100,000.[1]

The report shows that people living in rural and remote areas have higher rates of hospitalisations, disease, mortality, injury and poorer access to health services compared with those living in metropolitan areas. Providing equitable access to services remains the big challenge for the NSW Government. The current, devolved LHD model does not make centralised planning and achievement of uniform clinical outcomes easy. There is no coordinated vision.

There have been recent reports in the media about adverse events and avoidable deaths occurring in rural hospitals such as Broken Hill, Dubbo and Manning Base Hospital. Reporting of these events has increased public concern about rural and regional health outcomes, prompting this NSW Upper House inquiry.

Programs that Provide Infrastructure and Funding Can and Do Make a Big Difference to Outcomes

When there is a large state-wide effort to plan services, and to provide the infrastructure and resources necessary to run them, in appropriately chosen geographically located regional and rural hub centres, large improvements in health outcomes can be achieved. One of the best examples of this is the rural cardiac catheter lab program, combined with a clinical program – the State Cardiac Reperfusion Strategy (SCRS). This work was initiated by State-wide Services, a branch of NSW Health that no longer exists under a devolved LHD model. The Cardiology data from the Bureau of Health Information (BHI) for 30-day acute myocardial infarction (AMI) mortality does show an improving trend in NSW over the last decade (comparing the 2009-12 report with 2015-18 figures), particularly for rural patients able to be admitted directly to rural cardiac centres. These rural cardiac centres all achieved a lower than expected mortality for their patients, when adjusted for expected mortality based on age and co-complexity in the 2015-2018 report.

Funding for Such Programs Needs to be sustained long-term with Clinical Oversight to Ensure Patient Care Goals are Achieved

[1] https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/health-status-and-outcomes

Despite investment in infrastructure, such as the above example of Cardiac catheter labs, gaps in outcomes remain. The NSW Health State-wide Services unit which commenced this equity of access program, no longer exists and there is no centralised agency that is funded and scoped to review the performance of such programs or oversee the equal funding and further development of clinical services at rural hub sites. The Agency for Clinical Innovation (ACI) does not have the resources, nor the power to insist that LHDs develop an appropriate standard of service and clinical outcomes. Whilst all LHDs, except Southern NSW (where patients are transferred to Canberra, ACT) do have cardiac catheter labs, not all LHDs run them 5 days per week and not all use them to provide 24/7 heart attack services. Hence the care provided in different LHDs is very variable, despite being provided with the same infrastructure.

Rural and Regional LHD boards Often Lack the Level of Corporate and Financial Experience Available to the Metropolitan Boards

LHD websites show the CVs of board members. The qualifications held differ considerably across NSW. Boards without members with extensive corporate and financial experience may struggle to manage resources in a way that can process business cases and spend funds wisely to expand services. Development of new services within existing resources can take considerable corporate and clinical leadership, not always available to Rural and Regional LHDs. As has been established, lack of funding and infrastructure hugely impacts regional and rural health outcomes, and thus the process of organising funding and projects needs to be effective and uniform across the state.

b. Comparison of Outcomes for Patients in Rural, Regional and Remote New South Wales with Other Local Health Districts Across Metropolitan New South Wales

BHI- Insight Series data[2] provides information which compares 30 day mortality for 5 key conditions in centres across NSW.[3] From this data, it can be seen that larger rural centres compare reasonably well for some conditions. Outer metropolitan areas often perform below the level of inner metropolitan centres. Improving outcomes means improving access and funding to match clinical need and patient volumes.

Historical funding models have not been fully adjusted for under the Activity Based Funding (ABF) model. Examination of the number of registrars at each hospital in each specialty in comparison to the clinical work done in that hospital would serve as an example. Large central metropolitan hospitals have large numbers of advanced training registrars, even if much of the

[2] https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0005/339143/report-insights-Healthcare-in-rural-regional-and-remote-NSW.pdf page 101

[3] These conditions include heart attacks, stroke, hip fracture and pneumonia

work they used to do is now performed in outer metropolitan and regional/rural centres. Outer metropolitan and regional centres are performing the work with fewer registrar resources. Shifts in population demands and hospital activity needs to be translated into genuine shifts in resources including staffing and funding models.

According to the above Australian Institute of Health and Welfare report, the potentially avoidable death rate for people in major cities is 91.6 per 100,000 and in very remote areas (such as Broken Hill) the potentially avoidable death rate is 248.7 per 100,000 population (an increased risk rate of 2.7). This indicates significant scope for targeted programs to improve outcomes.

To Improve Clinical Outcomes Needs Clinical Key Performance Indicators (KPIs)

The KPIs for the LHDs and targets set are mostly volume or timeframe based and focus on financial measures. In order to improve clinical outcomes, KPIs must be clinically based. Unless this occurs, management teams across the LHDs will not focus on clinical measures and will not engage with strong clinical leadership.

To Improve Clinical Outcomes Needs Uniform Handling and Reporting of Clinical Governance Units (CGUs)

Clinical governance units (CGU) in different LHDs vary significantly in their standards of reporting and philosophy. MSCs in regional areas have provided examples to NSW MSEC of CGUs inappropriately downgrading adverse clinical events, poor reporting and follow up and have highlighted a lack of senior clinical leadership by doctors.

Uniform standards of CGU structure and reporting which are routinely examined and supported by a centralized NSW agency are required. The CGUs need to be focused on genuinely optimizing patient care, rather than perpetuating a culture of opacity aimed at keeping the Ministry of Health unaware of the LHD's true performance in clinical care.

c. Access to Health and Hospital Services in Rural, Regional and Remote New South Wales Including Service Availability, Barriers to Access and Quality of Services

Rural health reports and AIHWA provide some data on prolonged waiting times and poor access.[4] According to self-reported data, patients reporting barriers to seeing a GP in outer regional areas were 2.5 times higher than in metropolitan areas, and 6 times higher in remote

[4] https://www.aihw.gov.au/getmedia/838d92d0-6d34-4821-b5da-39e4a47a3d80/Rural-remote-health.pdf.aspx?inline=true

areas. 30% of patients in outer regional areas, and 58% in remote areas reported barriers to seeing a specialist. Access to specialist care remains a big problem due to reduced number of specialists per capita in regional and rural areas. The rate of specialists declines substantially with increasing remoteness from 143 per 100,000 population in major cities to only 22 in very remote areas. There are ways to address this, but the current system does not do so (see below). Encouraging specialists to relocate to regional and rural areas would be beneficial for many reasons, not only in providing improved healthcare in regional areas, but by providing economic benefits to regional communities by decentralisation of health professionals and their families to regional areas, by decreasing the oversupply of medical practitioners per capita in metropolitan centres, thereby reducing the over-servicing of metropolitan communities. The Medicare overspend that goes with an oversupply of providers in metropolitan areas has been the driving factor for the recent MBS review. Whilst this may be a federal versus state issue, as we move into challenging health economic times, due to an increasing aging population, anything that can assist in providing more equitable distribution of the whole medical workforce is likely to promote more cost-effective health spending.

Provision of a Specialist Workforce in Rural and Regional Centres

In order for a specialist to locate to a regional area, usually requires an appointment of some kind to a regional hospital. In metropolitan centres specialists have more private options available, but these are very limited in a rural/regional setting. Public hospitals, under funding pressures, mostly employ specialist medical staff to replace those who have left or retired for the purpose of immediate inpatient care and it can often take a number of years to gain approval for an additional specialist to be employed, even if the business case is almost cost neutral. Without changes to this current system, addressing the major shortfall per capita in the number of specialists is unlikely to ever occur. The per capita deficit leads to poor access for outpatient care. Even large rural hubs are mostly operating on half the number of specialists required per capita in order to service inpatient and outpatient needs.
Lack of approved and funded advanced training specialty positions in rural hubs is a further barrier to long term recruitment and retention of rural specialists. Advanced trainees improve the vigilance of teams and the cognitive load for specialists as well as providing training in locations that a junior specialist may decide they want to settle in.

While it is possible to provide a large local specialist workforce in larger regional hospitals, when positions can be approved and funded, this is not as easy in smaller regional or remote hospitals. Clearly filling both acute and critical care as well as outpatient specialty services with International Medical Graduate (IMG) specialists is neither practical nor feasible.

A possible solution would involve “networking” the smaller and more isolated hospitals with larger regional and metropolitan hospitals, and this would allow a regular and reliable supply of Specialists to visit the more remote and rural hospitals as well as ensuring adequate retention of

continuous professional development and clinical skills. This practice would also result in an improved standard and consistency of care. Networking between hospitals would also result in improved access to larger regional and metropolitan hospitals for patient transfers due to improved communication and handover between medical and surgical specialists.

Lack of Centralized Oversight of Access and Service Development Impacts Access to All Services

The devolved LHD model makes it very hard to develop and fund any new service, as LHDs are focused on staying within tight current budget constraints with a natural tendency to continue current models of care rather than investing in expansion of services.
Population shifts with large numbers of retirees in regional and rural areas means that a better co-ordinated approach to service planning and delivery is needed in many areas such as cancer services, advanced surgical services, radiotherapy and palliative care.
The rural population of NSW deserve uniform standards of healthcare. They want a doctor to be available in their local rural hospital; not a doctor attempting to provide a service from a distance. The LHD model is flawed in providing this. It has not realized any increase in local decision making, particularly not any engagement with healthcare staff, as evidenced by board minutes in most LHDs lacking any evidence of regular engagement with the local public or with staff including Medical Staff Council (MSC) input. The LHD model does not have an ability to control resourcing and clinical standards and ensure uniformity of access. The public have resorted to political lobbying when the LHD model has failed in engagement; for an example see the WNSWLHD Push for Palliative Care movement.

d. Patient Experience, Wait Times and Quality of Care in Rural, Regional and Remote New South Wales and How it Compares to Metropolitan New South Wales

Wait times for specialist care are undeniably long in regional and rural areas, as are wait times for rural GPs. The above discussion in sections a, b and c outline how regional and rural patients experience significant barriers in accessing both GP and specialist care. Barriers to access can lead to poor outcomes, poor patient experience and quality of care. Additionally, lack of funding and infrastructure as discussed above can contribute to poor access and increased wait times. The NSW MSEC believes that these issues would be addressed by taking the actions discussed above to improve service planning and delivery.

e. Analysis of the Planning Systems and Projections that are Used by NSW Health in Determining the Provision of Health Services that are to be Made Available to Meet the Needs of Residents Living in Rural, Regional and Remote New South Wales

When the LHD system was set up, the State-wide Services section of NSW Health was disbanded. No part of the organization has adequately filled this role since, and this issue has been raised with the Secretary and the Minister by NSW MSEC on many occasions. Whilst both the Minister and Secretary were in agreement that this function no longer existed, a discussion paper on how to address this was promised but has not yet been received. The devolved LHD system has no real scope to address long term planning and equity of access issues on a state-wide scale and there is no Department within the NSW Ministry of Health with the expertise or the brief to address the long term issues of poor access to medical care within rural and remote services. The Agency for Clinical Innovation (ACI) was tasked with recommending best models of clinical care. However, the ACI is not sufficiently resourced to analyse state-wide clinical performance, nor to ensure compliance of any LHD with a given clinical program or state-wide initiative. The LHD system is focused on making limited resources meet increasing demands and rural LHDs, in particular, have limited financial resources, skill and planning expertise available to them in order to commence new services, even if they are needed.

Re-instating a centralized State-wide Services body that addresses provision of key services (such as cancer services, cardiac services, trauma, stroke and paediatric critical care) is crucial if the equity of access and service development in response to shifts in population and demographics is to be achieved in regional and rural areas.

There is also a need for each LHD to develop a Clinical Services Plan which is updated every 5 years and, as a benefit of this plan, each LHD would be able to develop a strategy for the provision of a Medical, Nursing and Allied Health Staffing Plan.

Uniform clinical standards and models of care can only be achieved if there is state-wide oversight of standards by agencies which are resourced appropriately and focused on honest reporting on behalf of patients, on improving standards and not focused on cover up or making an organization look good. Neither the Clinical Excellence Commission, nor the Agency for Clinical Innovation are resourced for, or involved in, routine oversight of standards of care and clinical governance. System performance is openly reported by the BHI, but only every 3 years.

f. An Analysis of the Capital and Recurrent Health Expenditure in Rural, Regional and Remote New South Wales in Comparison to Population Growth and Relative to Metropolitan New South Wales

The major issue in rural and regional areas is that the cost of providing a service is often greater than that of providing an equivalent service in a metropolitan location. This is due to many factors such as greater staff costs due to locum fees and the lack of economy of scale.

Regional and rural areas have an aging population with high rates of co-morbidities. These older and sicker patients often with greater rates of unhealthy lifestyle factors (such as obesity, smoking and excess alcohol intake) along with a reduced level of access to preventative medical care, have a higher hospital utilization per capita. This results in a higher average cost to provide care for these inpatients in a regional and rural setting.
With an increasing incidence of chronic illness and resulting hospitalization and adverse outcomes in rural and remote areas per 100,000 population, there is a need for detailed costing estimates of the health expenditure on this group of patients both in terms of poor access to medical care and also poor illness prevention strategies (eg. obesity, diabetes, smoking and alcohol interventions).

Planning agencies should not lose sight of the fact that investment in rural and regional hub hospitals puts money that would otherwise be spent on transport to larger hospitals into local provision of care, local jobs and invests in building capacity for the future. This shift in funding and investment of healthcare dollars is needed urgently, as a model reliant on transfer of regional and rural patients to metropolitan centres is fundamentally more costly with an enormous waste in cost of bed days occupied by patients waiting to be transferred between facilities, rather than on bed days for actual care. There also needs to be clear and agreed guidelines which enable patients to access tertiary facilities with a minimum of delay and cost to the patient.
Centralized care should be reserved for those subspecialist problems that are truly low volume and high risk/cost eg neonatal and paediatric critical care, paediatric cardiac surgery/transplant; adult transplant services; hyperbaric therapy – none of which can be supplied by many or most of the LHDs.

g. An Examination of the Staffing Challenges and Allocations that Exist in Rural, Regional and Remote New South Wales Hospitals and Current Strategies and Initiatives that New South Wales Health is Undertaking to Address Them

There are many staffing challenges in rural, regional and remote NSW. In some cases, staff cannot be attracted to fill vacancies that are funded and advertised. In other cases, doctors are ready and willing to move to a rural location but there is no approved and funded position. It can

take years of negotiation and business case submissions to gain approval for a new specialist position.
Many specialists in regional locations are already working so hard themselves, they lack the time or perseverance to lobby for improvements in staffing and service provision in the current model. This point has also been covered above under (c).
GPs in rural hospitals are disappearing rapidly with many towns without any medical presence. Many retreated from hospital work as the result of failure to negotiate suitable packages to retain and support their hospital practice. Rural GPs need a sustainable mixed employment model; combining hospital practice (VMO), paid for by NSW Health State funding, with rooms (Medicare), funded via Federal spending. Appropriate incentives to move to and live in rural towns have been whittled away. Better educational support, locum backup and adjustments to the Medicare Benefits Scheme (MBS), to add value to services provided, need attention.

In the meantime, the regional areas remain understaffed per capita for specialists, patients continue to wait lengthy times to see a specialist and the specialists who are in the regional centres risk overwork and burnout.

There is no unified strategy by NSW Health to develop a medical and nursing action plan to staff rural and remote hospitals as far as NSW MSEC is aware. Each LHD is left to make its own plans and more focus appears to be on the LHDs achieving certain financial KPIs than attaining an acceptable standard of clinical care and meeting clinical KPIs. Small hospitals are more and more frequently without a doctor resulting in acute care being bypassed to a larger hospital, often many hundreds of kilometers away.

h. The Current and Future Provision of Ambulance Services in Rural, Regional and Remote New South Wales

Additional ambulance services would make a big difference in improving health access and outcomes in regional and rural areas. Many remote hospitals are supported by a program called CERS assist (Clinical Emergency Response Systems), a program developed by the Clinical Excellence Commission (CEC) and NSW Ambulance. CERS assist allows a paramedic to be called on to help a nurse in an emergency situation, where there is no doctor at a small facility. This is an excellent system which can and does save lives. For this program to be utilized more often to assist deteriorating patients, in under resourced locations, would require an additional staffing pool of paramedics across a couple of towns, so that there are sufficient resources to cover. There are a surplus of trained paramedics graduating who do not have jobs. Better utilization of this trained resource by increased funding would assist rural populations. Co-operation between NSW Health and NSW Ambulance agencies could develop models to utilize more paramedics in frontline care in smaller sites that may not always be able to supply onsite doctors.

There is an inadequate system for transporting children in ambulances – safety of securing babies and children on stretchers and in monitoring during transfer requires address at a state-wide level.

i. The Access and Availability of Oncology Treatment in Rural, Regional and Remote New South Wales

Additional resources and funding for Haematology and Oncology positions in regional hub centres are required. There has been development of radiotherapy services in regional and rural areas, and this has led to more patients being able to complete cancer treatment in regional centres. However, there has been insufficient modelling of the workforce of specialists in Oncology, Haematology and Palliative Care services to meet this change in regional centres and there is a deficiency in the current workforce in regional and rural centres that needs to be accurately quantified and addressed.

j. The Access and Availability of Palliative Care and Palliative Care Services in Rural, Regional and Remote New South Wales

With an increasing proportion of the population of rural and regional LHDs aging and suffering from co-morbidities, there is an increased need for chronic care and Palliative Care services which is mainly a funding issue. Determining and addressing regional population needs requires better modelling and workforce planning.

k. An Examination of the Impact of Health and Hospital services in Rural, Regional and Remote New South Wales in Light of Indigenous and Culturally and Linguistically Diverse (CALD) Communities.

Regional and rural areas have a high percentage of people who identify as Aboriginal or Torres Strait Islander. Diminished rural access to services therefore affects Indigenous Australians disproportionately, contributing to the gap in health outcomes. There is a lot more that could be done in this area, but it requires additional funding. Aboriginal Liaison Officer (ALO) staffing levels in rural hubs are inadequate and the position of an Aboriginal healthcare worker/care coordinator has been proposed, but not funded.

A 2-pronged approach to improving the health outcomes of Indigenous Australians would be to provide greater funding and resources to regional hub hospitals to improve service level and access to services for all regional and rural people, both Aboriginal and non-Aboriginal. In addition, there is a need to improve funding of ALO and Aboriginal healthcare workers to address specific culturally appropriate case management and connecting care needs.

Additional funded programs to support the education and training of ALOs, Aboriginal Care Coordinator positions and a greater number of Indigenous health care workers would all be beneficial in better catering for the needs of regional and rural people who identify as Aboriginal and Torres Strait Islander.

l. Any other related matters

Lack of Administration Engagement with Clinicians

Many of the issues regarding poor regional and remote health outcomes, access, quality of care and infrastructure would be remedied if the people administering the system better engaged with clinicians in clinical service planning. The LHD system is designed so that the MoH primarily engages only with Board Chairs and CEs, with an over-reliance on the self-reporting of performance and of issues, and the KPIs that trigger Ministry intervention are mostly financially focused. This system ensures that clinician suggestions and input regarding effective service planning are often lost or otherwise devalued. In 2018, the Auditor General Conducted a Review of NSW Health governance systems.[5] For a detailed review of the issues with the current LHD structure and governance systems, please see the attached document, which was the NSW MSEC's submission to the Auditor General.

Lack of Separation between Administrators and Regulators:

The LHDs report to NSW Health through the Chief Executive and this lacks transparency as part of the service agreement. There is no verification of clinical governance structures and the accuracy of reporting.

Even when issues relating to suboptimal clinical governance performance are raised (for example Broken Hill), NSW Health may conduct its own investigation or commission a report from a contractor. However, such investigations are not entirely independent, given that the MoH have a vested interest in supporting the status quo and in maintaining consumer confidence on behalf of the government. Such investigations rarely openly report problems identified back to clinical staff or to the public and in most cases (including Broken Hill) the LHD is still charged with the task of implementing any recommendations arising, which is a difficult change management task when the problems have often occurred under the direction of the same managers charged with the remedy.

A review of an underperforming LHD requires sufficient independence to report issues honestly and make recommendations that allow accountability and improvement in systems for patient care. Timely implementation of recommendations needs to occur, with agency oversight that is external to the LHD.

[5] https://www.audit.nsw.gov.au/our-work/reports/governance-of-local-health-districts

Lack of Funding for the "Garling Pillars" to Adequately Perform an Independent Structural Role

The Clinical Excellence Commission was tasked with providing best models of care and ensuring standards across NSW. The resources to achieve this vision have never been provided and standards and models of care are not uniform. Resources are not uniform.
The Clinical Excellence Commission – could have been tasked with oversight of clinical governance reporting and structures in each LHD, but has never been assigned this role, nor resourced, to oversee standards.
The BHI produces data every 3 years, but there is no formal program whereby the relevant sections of the ACI or BHI examine the data and provide clinical leadership, investigation or advice on how the outliers, the poor performers across the state, can be assisted to improve their clinical outcomes toward the state average.

Lack of Any Avenue for Medical Staff to Escalate Concerns Beyond the LHD for a Fair and Objective Analysis

NSW MSEC exists as it has been created by MSCs and yet a formal state-wide body is not specifically mentioned in the health services act and does not have scope or funding to pursue its own investigation in the event of an MSC being unhappy with LHD management and unable to resolve issues within the LHD or via NSW Health. There is no formal, objective structure for dispute resolution.

Lack of Uniform Standards of Clinical Governance Units and Medical Recruitment and Credentialling Procedures in Rural and Regional LHDs

There is a lack of uniform Clinical Governance across LHDs, with procedures in rural LHDs highlighted in recent times. Far West LHD reported multiple instances of failure to address clinical concerns raised about governance structures and of the inappropriate regrading of SAC events and a failure to investigate preventable deaths. MSCs in WNSWLHD have highlighted issues with governance structures and reporting, and a lack of senior medical leadership in their CGU over a period of years.
Uniform standards across NSW for CGU grading of clinical incidents, reporting of findings, structures of medical oversight and external accountability would be advantageous to patient care.

Lack of Uniform Recruitment and MADAAC Procedures in Rural LHDs

Local Medical and Dental Appointments Advisory Committees (MADDAC) are either poorly functioning or non-existent for some rural and remote Hospitals. For example, BHH (FWLHD) is reliant on the MADDAC committee at the WNSWLHD and the FWLHD has difficulty filling

membership of the local MADDAC which could result in inappropriate appointments as locum VMOs at BHH due to a lack of Credentialling Committee oversight.
All LHDs need to have MADAAC resources, including subspecialty MADAAC subcommittees, that can ensure mandated NSW Health recruitment procedures are completed, in order to ensure that qualifications and level of experience of any doctors employed matches the clinical privileges and role that they are given.

The Role of Telehealth in Regional and Rural Areas

Telehealth can be a powerful tool to support both patients and clinicians in a regional and rural setting. One successful example has been the SCRS that has placed an ECG reading service in each LHD, to provide early specialist input into acute heart attack management. Telehealth services can be used to supplement rosters in regional and rural areas and make on call commitments sustainable for locally based doctors and nurses.
However, any telehealth model must carefully consider the acute, medium and longer term impacts of the intervention and whether this is the safest, best practice model of care for the patient. For example, a telehealth model that seeks to employ metropolitan based doctors, to provide afterhours care for rural patients, can be a flawed model for the following reasons:

1. Failure to invest in locally based medical workforce (doctors and nurses) has major impacts for the provision of long term care in regional and rural locations. Patients require hands on care and a telehealth model should supplement this and not seek to replace local providers.
2. Metropolitan based doctors providing telehealth services in rural areas do not always have a detailed understanding of the locations and the resources involved and unless they are orientated fully, this can lead to potential mistakes and suboptimal care.
3. Acute services that do not link to continuing care options of the patient, such as ordering key investigations and following up the results, are of little use to the patient, who may have no ability to be seen by a GP or specialist in a timely manner.
4. A telehealth model that acts as a transport system and distribution service, rather than a virtual hospital linking patients early with specialists and seeking their timely input and advice on patient care, is also a poor model. The remodelling of the telehealth service in WNSWLHD from the former “Critical Care Advisory Service” which was led by emergency and critical care physicians who were locally based across the rural LHD, with extensive knowledge of the area and the other clinicians, to the “vCare” unit directed by a clinician based in Sydney, has seen a major shift in the direction of this service. Multiple concerns have been raised by all specialty groups at Orange, the major rural hub hospital in WNSWLHD. Other services such as NETS – use a different ‘telemedicine’ model to enhance rather than replace local care. NETS and ACC (NSW Ambulance) have found the VCare model delays access to urgent advice and care by adding multiple layers to the communication process. Virtual care is not an alternative to an appropriate and adequate local medical and nursing workforce. The clinical concerns with the model are yet to be fully addressed.

Key Points in Order to Improve the System in the Key Areas of Service Provision and Equity of Access for Regional and Rural Communities;

1. Immediate re-instatement a body that looks at state-wide services and equity of access across LHDs particularly rural and remote areas. Role being to determine where key services (e.g. cancer, cardiac, paediatric, obstetric, stroke etc) need to be **across** the state and to fund them. Ensure new services are equitably distributed and resourced. Ensure Rural/Metropolitan networks are effective and serve the needs of the rural communities.
2. Examine and reform how specialist positions are allocated and funded at regional hub centres.
3. Separate management and audit functions of health service provision.
    a. Give the "pillars" resources and power to perform the role of innovation and of audit and compliance, completely independently of NSW Health.
    b. Review all SAC1 Critical incidents in rural and remote areas and response to these by each LHD
        - Inquiries commissioned by either NSW Health or by an LHD are paid for by the public and should have greater public transparency in the reporting of their findings and recommendations. For example, the "Denis Smith" Inquiry April 2019 *"Review into the Operation and Effectiveness of the Medical Services and Medical Credentialing functions at the Broken Hill Health Service".* This inquiry presented 30 recommendations in April 2019 and very few of these recommendations had been adopted by the FWLHD in early 2020. Oversight of the implementation of major clinical and Governance recommendations of external reviews would be better supervised by an external agency – such as an appropriately resourced "Pillar", rather than the LHD-NSW Health axis that has self-reporting and self-examination conflicts.
        - BHI reports should inform audit and improvement procedures. Hospitals and/or LHDs that perform poorly in a 30-day mortality category should be examined by external clinicians with expertise able to analyse where problems may lie and how to improve them. Without action on data, opportunities for system improvement are lost.
4. Clinical Governance Structures should be uniform with external audit/ oversight
5. Clinical appointment processes and MADAAC functions should be uniform and compliant with NSW standards, with external oversight.
6. Historical resourcing allocation to large metropolitan centres versus rural hubs should be re-examined, on the basis of service provision/volume shifts.
7. Ensuring there is a stable and competent workforce at rural and regional hospitals will require adequate workforce planning, a functional medical appointments process and (most importantly) networking with larger regional and metropolitan hospitals to ensure a stable and sustainable senior and junior medical workforce.
8. Use of telehealth models in regional and rural areas needs to be carefully examined in order to ensure that a service meets patient needs. Telehealth can be a powerful addition that can supplement and support locally based clinical services. Telehealth cannot replace the development of a locally based medical workforce. Systems of care, including provision for

timely patient follow up and for the acute monitoring and escalation of clinical concern about a patient in a facility with only telehealth, need to be safe and robustly reviewed.

9. Telehealth models need local Rural and regional leadership and experience in healthcare provision in the setting where they are provided.

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