Clinical Excellence Division

Driving change that delivers improvements

Statewide Rural and Remote Clinical Network forum report
30 November 2017

Queensland Government

Driving change that delivers improvements

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Introduction

The challenges laid out to rural and remote communities with regard to their health needs, and how to best address those needs are many and varied. Workforce is but one of the key issues, along with multiple social determinants, all impacting individually and separately, in varied amounts on rural communities.

Issues related to Rural and Remote Health Workforce were discussed, developed and debated wholeheartedly at the Rural and Remote Clinical Network Forum held on the 30th November 2017 at the Royal International Conference Centre. Identifying those levers and sticks in the system that could be recognised as the "drivers" for change that "deliver" to rural communities is important. It is often those steps being identified that allows health providers, communities, stakeholders and system managers to develop solutions addressing the needs of those rural communities under strain.

The issues surrounding Rural and Remote Health Workforce have been prominent of late. The completion of the Medical Workforce Plan 4 Queensland has been amongst a raft of other reports handed down and developments seen across the state of Queensland and Federally. The appointment of a National Rural Health Commissioner with a brief to oversee a rollout of a National Rural Generalist Program and to address issues of workforce maldistribution, training and incentives programs has been a key development.

On the day there was a clear commitment to learn from each other, network with new and old acquaintances and engage in an open process whereby delegates could share their trials, their triumphs and develop solutions to the problems placing challenges on our health systems.

Opening address

Dr John Wakefield PSM | Deputy Director-General (Clinical Excellence Division)

Dr John Wakefield, himself a previous ‘rural doc’ from time spent in the Wide Bay Area, provided the opening address, highlighting the already committed care being provided by dedicated teams in rural communities.

Dr Wakefield, in encouraging and recognising the need for development of resilience models in rural communities identified clear challenges. These related to current economic cycles, the ongoing nature of geographic isolation and the need to counter the disparity in known health outcomes with rural communities, in the vast majority of situations, falling far behind urban and metropolitan areas. He clearly valued the good work being done by networks currently to essentially ‘smooth out’ the differences in level of care being provided to rural communities.

It was recognised that there are some clear specific areas of need to be addressed across multiple rural communities. Mental Health has been one of these. While generalisation, rather than ‘sub-specialisation’ is a key driver to assist in addressing such disparities of care in clinical areas across rural communities,

it is not the panacea on its own.

Dr Wakefield fronted a long list of presenters, thought leaders and stakeholders who were able to further set the scene and inform the assembled delegates of the issues affecting rural health workforce in the current climate. For example, it was recognised that while there would be an increase in the medical workforce in Queensland alone in four years of 2500 medical officers, the maldistribution of that workforce is a challenge still to be addressed. Further, there appears to be data developing supporting the fact that there are also enough nurses to manage current demand - however there is also a maldistribution along the lines of the medical challenge to also be addressed.

Workforce and strategy

There are green shoots though. Queensland Health has committed $12.57M in the last budget to address poor rural and remote accommodation under the governments Rural and Remote Health Workforce Strategy. In addition to this there has been expanding commitment to development of Rural Clinical Leadership programs as well as $1.05M across three years for the Rural Doctors Upskilling Project.

The government has been seen to be active in this space recently and is to be commended for the response to the identified drivers of quality accommodation, clinical leadership and workforce skills maintenance. It has been seen as keen to take further action to address the drivers to deliver the outcomes that rural communities need. In identifying those outcomes, consumer targets have also been identified. Encouraging the development of ‘patient focused’ culture targets including facility cleanliness, improved clinician communication and improved cultural capability amongst clinicians are seen as measures of success in achieving those outcomes.

Consumer concerns

The consumer voice is a firmly entrenched and valued commodity when discussing improved access to quality health services in rural communities. Consumers are identifying that to achieve improved health outcomes, support in areas such as training and new technologies, with the two areas being interchangeable, is needed. The role outs of TEMSU (Telehealth Enabled Medical Support Unit) and Telehealth in general have been seen as integral to these developments.

Margaret Woodhouse, proactively representing the consumer voice of North Queensland quite clearly identified the importance of community advisory networks and the role they have to play in directing/determining the services provided to their communities. Margaret's key points around communication, education, inclusion and innovation resonated with the delegates assembled - with the need to have a bit of fun along the way provided a moment of levity prior to getting into the nitty gritty of funding models and Workforce establishments and the discussion to follow.

Funding and workforce models

Key concepts were developed within this session. These included:

- Trying to remove the driver away from rewarding activity (and acute hospital care)
- Acknowledging the burden of disease
- Rewarding primary care - how can this be better done
- Considering the need to manage the inequities prevalent in the delivery of healthcare

Robert Seaton, Principal Health Analyst, Patient Safety and Improvement Service, provided a significant overview of the Atlas of Healthcare Variation and the Value Based datasets that were considered. The Atlas of Healthcare Variation is a significant resource to be used in the context of considering where health inequities lie and how to better target health resourcing. All those involved in the provision of healthcare would be encouraged to at least consider how the Atlas compares their local community to the considered averages and the local capacity to address inequities should they exist.

Three separate presentations were provided by Dr Ewen McPhee a GP from Emerald, Dr Dan Halliday, Medical Superintendent in Stanthorpe and Associate Professor Bruce Chater, Medical Superintendent with Right of Private Practice in Theodore. Amongst the key issues addressed in these case studies of communities with level 2 and level 3 hospitals, the ability to activate and leverage the available funding drivers was paramount. These funding drivers were also being managed in the presence of evolving Rural Generalist models of practice dependent on community need.

Ewen raised the issue of the political machine and cycles in place and knowing how to best manage those considerations to achieve the best outcomes for your communities. Dr McPhee left the assembled delegates with the challenge to consider "What would you do if you were Minister of Health for a day?"

Nursing and Midwifery remain prominent in current considerations. The forum was fortunate to have the Chief Nursing and Midwifery Officer, Adjunct Professor Shelley Nowlan to address its attendees. Shelley acknowledged the contributions of the medical and allied health rural generalist models and the need to build on the successes of those to develop the rural nursing workforce of the future. There was a well recognised acceptance that it is also far more economical to deliver care within the context of local communities and in the best interest of patients.

The delegates were interested to hear how the Business Planning Framework (BPF) developed and evolving from the Office of the Chief Nursing and Midwifery Officer is being rolled out to cater for changing models of nursing staffing. There was also an appreciation of whether there is application to medical and other professional streams.

A further initiative identified by Adjunct Professor Nowlan and discussed by attendees was the Nursing and Midwifery Exchange Program. This program is being gradually rolled out through the coordination of

the South West Hospital and Health Service. Interest and uptake is growing in this and the hope is that rural nurses and midwives will be able to access the skills development opportunities needed to enhance the provision of care in their home communities. Further, there is an opportunity for urban and metropolitan nurses and midwives to experience rural practice, gain an appreciation and possibly consider a longer term commitment.

These modelling processes were captured in the consideration of the Rural Doctors Association of Queensland (RDAQ) Traffic Light Model. This modelling process has been the result of a number of years of community advocacy and member engagement by RDAQ. The apparent engagement and questions fielded by RDAQ Executive Officer Ms Marg Moss and Past President Dr Michael Rice were testament to the relevance of the concept developed when considering rural community workforces at risk.

Hypotheticals and workshops

Combining the content and contextual experience of the presenters, delegates were able to engage with a number of experts in their field in a hypothetical discussing how you may manage the drivers needed to improve and empower a remote community with maternity services and high Aboriginal and Torres Strait Islander population when subject to mining development.

Further, subject experts in fields of remote and Aboriginal and Torres Strait Islander health, medical education and training and workforce and population health management contributed short workshops which enabled delegates to put their learnings for the day into practice. These were well attended and considered extremely valuable exercises by all involved.

Key issues to take out of these discussions included:

- The role and relevance of Queensland Rural Workforce in relation to the National Rural Generalist Program including further development of allied health and nursing models
- The significance of managing mental health in the rural context
- Aboriginal and Torres Strait Islander cultural capability when developing service integration models
- The importance in recognising remote (Level 1) services.

In moving forward, it may be worthwhile to try and consider, with some paraphrasing, the sage advice of Dr Colin Owen who said that in managing the needs of rural communities, what we need is ‘confident and competent clinicians that are comfortable and content.’

If we can achieve this we will be a long way to achieving our desired outcomes.