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## **Community health: the state of play in NSW. A report for the NSW Community Health Review**

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## Community health: the state of play in NSW. A report for the NSW Community Health Review

### Abstract

This is the second report to the 2008 review of community health in New South Wales (NSW) by the Centre for Health Service Development, University of Wollongong. It describes current clinical and management structures in community health and identifies existing gaps in service provision. It also examines issues such as linkages and referral pathways with general practice and other community-based health services and with acute and population health services.

### Keywords

review, nsw, health, play, state, report, community

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# Community health: the state of play in NSW. A report for the NSW Community Health Review

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## Executive Summary

### The best of times ... the worst of times

*'It was the best of times and the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way – in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only.'*<sup>1</sup>

### Solid facts

Based on an audit by NSW Health in 2008, NSW expenditure on community health increased from \$1.2 billion in 2004/05 to \$1.5 billion in 2006/07. Despite this reported increase, overall expenditure on community health declined as a percentage of total expenditure from 18.0% to 14.5% over the same period. This is due to significant increases in hospital budgets over the same period. Information gathered during our field conclusions suggests that some of this relative decline is due to changes in how services are organised. However, this is not the sole explanation, with evidence to the review suggesting a genuine reduction in community health staff in the three year period.

This pattern was also found when funding for admitted patient services was excluded. Each year community health has been receiving a smaller proportion of funding allocated to non-admitted services, with funding for community health declining by 5.8% relative to other non-admitted services.

There are significant differences in the level of community health investment across areas, with Greater Western spending more money per capita on community health (\$375 in 2006/07) than the other areas. At the other extreme, Sydney West spends the least (\$187 in 2006/07), with spending in Sydney West representing less than half that spent in the Greater West. While there were some methodological difficulties with the audit undertaken by NSW Health, the overall findings raise serious questions about the balance of health investment in NSW. The results also raise serious questions about equity of access to community services across the state.

### The scope of community health

All Areas provide the majority of the community health streams that we outline in Section 7.2 (page 19). The bulk of these services are managed by Primary and Community Health Services with Population Health providing strategic leadership or managing Area-wide health promotion and priority population health programs for Aboriginal Health with some joint service delivery on the ground.

With the exception of the specific issue of hospital demand management, there is a majority (but not unanimous) view both within the Health Department and in the field on the future role of community health - community health should provide the full range of services from prevention to palliation.

Implicit in proposals to define a core role for community health (which was one of our Terms of Reference) is an assumption that at least some of what community health currently does can be either ceased or shifted to other sectors in favour of a set of core services that are more effective. The review of the international evidence commissioned as part of the current Review was

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<sup>1</sup> Opening paragraph of Charles Dickens' second historical novel A Tale of Two Cities (1859) set in London and Paris before and during the French Revolution

designed to inform this issue (see our compendium report) and the conclusion there is that there are few solid facts to guide a strategy that involves selective disinvestment. But that does not mean that there are no opportunities to improve the efficiency of community health, an issue which is addressed in our final report.

### Models of good practice

The Review received information on good model of cares that are large-scale programs or service redesign initiatives and that have been researched and formally evaluated. But these are in the minority. This reflects the lack of investment in primary health care research and development and in systematic clinical redesign outside hospital or hospital community interface settings. The majority are case studies of local or Area initiatives that have been documented and assessed locally and illustrate a commitment to service improvement, better targeting of priority groups or smarter service delivery.

A key theme throughout the Review has been the growing need for hospital demand management services designed to prevent avoidable admissions, to facilitate early hospital discharge and to reduce the rate of hospital readmissions. There is no consensus on how hospital demand management is best organised and delivered, with some believing that it is best managed by community health and others believing that it is best managed by hospitals.

### Service gaps

Short-term hospital demand management services have been increasing at the expense of other services in the community, particularly prevention and early intervention. The Review received consistent feedback on the shortage of psychosocial counselling (particularly in metropolitan areas) and youth health services, as well as the limited capacity to sustain home visiting for high risk families everywhere. There are very limited evidence-based early intervention programs for young people with early onset psychosis and other mental health problems. There is also limited access to allied health treatment, with many people assessed and on long waiting lists.

A further and related issue is the trend to establish more tightly defined micro programs, each with their own eligibility criteria and narrowly targeted recipients that limit the capacity of community health services to flexibly respond to local needs.

### The disappearing generalist

The right balance between specialist and generalist primary care was well summarised for the Australian context by Gunn et al (2007) in their recent review of 'generalism' in primary care who describe:

*'the sense of urgency and alarm in...much of the international literature about the devaluation, loss and downfall of generalism within primary health care systems'.*

A number of submissions to the Review saw no conflict at all between generalist and specialist models, pointing out, for example that:

*'the local community health centre could provide a very valuable ongoing support service to young people with high support needs and significantly improve their health care and quality of life.'* (Submission to the Review from Dr Carolyn West, Director Spina Bifida Unit, The Children's Hospital at Westmead)

*'This is not an argument for the separate identity and provision of community based health care, but for resetting the balance between hospital and community components of integrated health services, and shifting the centre of gravity of such services towards more accessible community health services.'* (The Future of Community Health Services in Australia, submission to Review from Alan Rosen, Roger Gurr & Paul Fanning)

At least in part, the increasing trend towards establishing specialist teams within community health is due to the inclusion of components of community health services within hospital, sector or area clinical streams. This is particularly the case for community health services located in those areas

that have principal referral hospitals, with the specialist teams in the community reflecting the sub-specialist structures of the hospitals or through the role of population health.

The right balance between community and hospital and between generalist and specialist services cannot be determined in isolation but is part of a set of bigger issues about the role of community health services and where they fit within the broader NSW Health system. This issue is addressed in our final report.

### **Governance**

A key issue for the Review is whether a 'one size fits all' governance model can or should be implemented in NSW, given the size of the current Areas, their different health service architecture and diversity of population needs.

Based on an extensive consultation across NSW, our conclusion is that a single organisation and governance model is unlikely to work across NSW. However the policy environment suggests the need for high profile primary and community health leadership at strategic levels within the system with the authority and levers necessary to drive change and improvements in health services and to build effective primary health care partnerships.

### **Joint action**

A further issue, illustrated in community mental health, is that there is evidence that joint planning, community location and service mobility results in better outcomes than hospital-based ambulatory services. The main issue is how to make these models more sustainable and with wider application. There are numerous examples of pilot studies in selected areas supported by memoranda of understanding and so on in collaboration with Housing NSW, Justice Health, Corrective Services and DADHC.

### **Workforce flexibility**

Many informants believe that community nurses need to fulfil a role similar to District Nurses in the UK National Health Service. These highly skilled primary health care practitioners provide care in partnership with local GPs for families and patients with complex needs and navigate patients to the allied health, hospital and support services that they need. Others spoke of the need for highly skilled rural generalists or primary health care nurses who practice in remote areas without local backup.

Many informants believe that there is a need to reassess and clearly articulate the practice approach, skills and competencies required in the generalist and specialised community nursing and allied health workforce. This would then lead to workforce planning including meaningful workload measures for a variety of community health roles and service settings.

The impediments to greater flexibility are not in a lack of innovation and models to create improvements in efficiency. The key challenges are in the sustainability of these models and in creating the right incentives and opportunities for their wider implementation.

### **Information and planning systems**

In terms of the strategic direction for community health, moving beyond a largely transactional data system is essential. If community health services are to be in a position to demonstrate what they do and the outcomes they achieve, the capacity to capture care goals and outcomes is fundamental at the start and not something that might be built in at a later date.

On the one hand, many executives and managers at both the departmental and area level are critical of community health services because they cannot demonstrate what they do. On the other, neither the data systems nor the information technology are in place that would allow community health services to do otherwise. A major investment is required.

While there are well developed planning tools and models for acute hospital services, there is a dearth of equivalent tools for the planning of community health services in NSW. Investments are needed in a service planning, classification and decision support tool to assist plan the best service mix in each location.

Work towards a standard classification of community health services and interventions and routinely collected data that can be used to inform future planning requires central support. While these problems will not be resolved in the short-term, there is no reason why work to develop a much-needed 'Guide to Community Health Role Delineation' could not begin in 2009.

### Research and development

There are many examples of community health staff undertaking their own service evaluations and documenting what they do in reports. However, there is no systematic investment in R&D and not a strong R&D culture. Further, there is no central repository of best practice information on community health and no central community health knowledge management strategy. There are models in the literature of population-based research that include researchers working in collaboration with their communities, with research findings being incorporated into daily practice to better meeting immediate care needs and to directly influence popular expectations.

### Revitalising community health

Despite the range of community health services being offered, many informants feel that community health had become 'invisible' in their Area and that the focus on promotion, prevention and early intervention is being overwhelmed by hospital demand. Many community health centres are run down and services are being increasingly relocated back to hospital campuses, with implications for reduced access for those clients most in need of publicly funded community health services.

There are mixed views on how best to re-vitalise community health, what the best governance and structural options for the future are, and about the best way to make progress. However, several themes have been consistent throughout the consultation process:

- Primary and community health services need to be at the table and to 'have and be seen to have' a clear role in supporting hospital demand management and avoidance to be relevant in this environment and to provide continuity of care for their existing clients.
- Without clearly defined primary and community health structures and effective leadership, the 'episodic illness' model will continue to overwhelm prevention and early intervention services for children, families and young people and will continue to reduce interagency partnership programs targeting at risk or vulnerable groups.
- Many acute hospital managers and clinicians, particularly in urban areas, are perceived to have limited understanding of the role and operation of community health and the service issues or models of care that have been developed to respond to the full range of population. This is especially the case in relation to community health activity targeted to clients who do not encounter the acute care system.
- Numerous examples were provided to the Review of hospital-based managers wanting to redeploy community nurses and community midwives to backfill hospital vacancies, with little concern for the impact on community workloads and models of care. These examples were interpreted as essentially cost shifting from hospitals to other areas of the NSW government's human services and to Commonwealth-funded services.
- Models in urban, regional and rural environments are different by necessity. Most senior executives and local managers in rural and regional areas support an integrated model as the only pragmatic approach for workforce reasons. This is especially the case in smaller health services where a primary health care approach is core business.
- There is a pervasive sense of weariness and fatigue, with restructuring in many Areas being unresolved. There is also widespread frustration that competing models of care and

administrative systems have still not been reconciled and that organisational structures that have been evolving since the last restructure in 2005 have not been finalised.

### **The starting point is where NSW is now**

The majority of community health services in NSW are now managed at a local level as part of an integrated health service system with shared operational management and funding arrangements with hospital services. However, the seniority and responsibilities of community health managers vary widely.

The current policy settings in NSW and nationally (and internationally) suggest the need for a vibrant community health service at the heart of the health system. There seems to be a strong majority view (if not consensus) on the desirability of that direction. But there are few coherent strategies in place on how best to practically achieve a community health and primary care-driven system.

This *State of Play* report has described community health in NSW in 2008 and a series of strategic issues are described. Our compendium report (*Community health: the evidence base*) synthesises the international and national evidence on community health interventions and services. These two reports inform the final report (*Community health at the crossroads: which way now?*) that sets out a proposed strategic direction for the future of community health in NSW.

## 1 Introduction

This is the second of three reports on the 2008 Review of Community Health in NSW (the Review) undertaken by the Centre for Health Service Development (CHSD), University of Wollongong.

The NSW Community Health Review is a strategic review that has three major components and eleven terms of reference. The major components are:

1. An audit of the scope of activity and existing investment in community health services undertaken by NSW Health. This audit was undertaken by NSW Health.
2. Analysis of gaps in current provision of community health services with a focus on service delivery, governance, linkages and referral pathways with other parts of the health system including general practice, other providers of primary care services and acute and population health services.
3. Development of a vision for the future role and operation of a revitalised community health service sector with a focus on core services to be provided by community health services, best buys and areas for investment and disinvestment and a staged pathway for reform.

The purpose of this second report is to summarise the current state of play in NSW. This report describes current clinical and management structures and identifies current gaps in service provision. It also addresses issues such as linkages and referral pathways with general practices and other community based health services and with the acute and population health sectors.

The first report (*Community health: the evidence base*) provided a definition of community health and primary health care and includes a brief history in the Australian context. This compendium report includes an overview of current pressures and drivers for change and places these in an international context as well as contemporary national developments. It summarises the local and international evidence for community health interventions within a population planning framework.

The final report in this series (*Which way now?*), builds on these first two reports. It is strategically focussed and designed to inform future planning and resource allocation decisions in NSW.

## 2 Scope

This is a strategic, not an operational, review. Its purpose is to inform the next stage of the Review, which will identify options for the future, rather than to review or evaluate how community health services are operating now.

For pragmatic reasons, the NSW Health Department limited the scope of the NSW Community Health Review to community health services provided by NSW Health Area Health Services. This decision was made on the basis that the strategic role of Non-Government Organisations (NGOs) may be considered at a later time.

In the context of the current Review, NGOs are key stakeholders rather than the subject of the Review, as are general medical practitioners and their allied health colleagues in the private sector and other government departments and central agencies.

While the scope of the review is limited to government managed community health services, it is important to recognise that community health is part of a broader primary care sector that includes general medical practitioners, private allied health providers and NGOs. As such, while the focus is on community health, community health cannot be considered in isolation.

## 3 Methods

Information from a range of sources has been analysed to address the Terms of Reference and strategic issues for the Community Health Review.

The component of the Review that was used to focus the content for this second report was the analysis of submissions and consultations mainly undertaken within the health system and to a limited extent with other parts of government and groups with an interest in policy and the strategic issues for community health.

Meetings, regular teleconferences, correspondence and workshops with the steering group and other key informants were used to get feedback on the issues raised by the consultations and discussion focused on the drafts of the strategic options.

### 3.1.1 Baseline audit

A baseline audit of community health service activity, resources and investment was prepared by the Primary Care and Partnerships Branch in NSW Health to provide background information for the Review. The data have been analysed and used in this report to provide a snapshot of trends in investment in community health services across NSW.

### 3.1.2 Stakeholder consultation and key informant interviews

Consultations were undertaken with a range of stakeholders to obtain information on the current role and focus of community health services, governance and partnership arrangements, gaps in service delivery and support systems and to elicit views on the key strategic issues and future priorities for Community Health Services.

The scope of these 60 days of consultations was not comprehensive. Rather, the goal was to consult with key stakeholders and informants who were identified as having views that reflect wider perspectives and who could contribute to the analysis of the strategic issues and themes emerging from the Review.

Consultations were undertaken in each Area Health Service and at Westmead Children's Hospital. Review team visits were organised by each Area Health Service and the format varied across the state, but typically involved key informant interviews with the Area Executive team and the senior Area Community Health Manager, as well as a range of informants. Each Area was asked to select the most appropriate methods for consultation and the key participants. The result in each Area was a series of scheduled interviews and meetings, forums and videoconferences with community health team leaders, hospital general managers, Area program directors and senior clinicians from across the Area, plus non-government organisations, carer and consumer representatives.

In relation to consultations with the Areas, it was necessary to emphasise that the aim was a strategic and not a comprehensive survey and not an operational review. Some participants had difficulty with that distinction, perhaps because of the plethora of organisational reviews and surveys that are ongoing in the system.

The issues and content covered at the consultations varied somewhat across the Areas, and between groups of participants, but remained focussed on the key strategic issues for the future. These strategic issues were identified relatively early in the life of the Review, and these were used for introductory remarks and setting the expectations of the consultations, allowing participants to focus on particular issues and themes, depending to some extent on where and when each consultation session was held.

Interviews were conducted in NSW Health with the Deputy Directors General, branch heads, program managers and key policy analysts, the NSW Community Health Directors' Forum and selected Health Priority Taskforces to obtain information on strategic issues, relevant state and

national policy directions and developments in relation to workforce, support services and information systems.

Briefings with general practitioners and Divisions of General Practice, non government organisations and representatives of other government departments and inter-agency groups were also scheduled in several Areas, as well as separately with peak organisations. Separate briefings and consultation sessions were held with General Practice NSW and representatives from 15 rural and urban Divisions of General Practice. Representatives of peak non government organisations including the Aboriginal Health and Medical Research Council, NSW Council of Social Service (Health Policy Advisory Group and the HACC Issues Forum), the Aged and Community Services Association of NSW and the ACT, Barnardo's, the Benevolent Society of NSW, the Men's Health Network and the Network of Falls Coordinators were also consulted.

The State Offices of the Commonwealth Departments of Health and Ageing and Families, Housing, Community Services and Indigenous Affairs were consulted and asked about their strategic views on current service gaps and ways of developing community health. Researchers and academics with expertise in primary health care and relevant officials in NSW departments and other states were contacted by phone and email and their various reports, evaluations and policy documents were accessed by email postings or through websites.

Consultations with other NSW human service departments and government agencies (Departments of Aboriginal Affairs, Ageing Disability and Home Care, Justice Health, Community Services, Police, Corrective Services) were scheduled to occur at a time that will be useful to inform the third and final report.

### **3.1.3 Submissions, examples of good practice and innovation and related information**

Community health staff and interested individuals and organisations were encouraged to contribute examples of good practice and innovation through the Review website and to provide submissions and recommendations to the Review. A list of submissions and links to examples of good practice were maintained on the Review website.

Area Health Services also provided a range of background information including service and strategic plans, evaluation reports, information on models of care and examples of partnership arrangements. These are included in Section 9.3 on quality and safety initiatives and in Attachment 2 under Table 4, which summarises the range of models presented to the Review. It is not a comprehensive listing.

### **3.1.4 On-line survey**

Community health staff and interested individuals were also invited to comment on the key strategic issues for the Review via an on-line survey. At the time of writing, 75 individuals have taken up this invitation so far and their views are discussed in this report. While this survey was not designed as a representative sample, the survey was an open opportunity for feedback on the strategic issues that the Review is considering.

### **3.1.5 Assessing the strength of the qualitative evidence**

The mix of methods summarised above was used to assess the context of the current system and the viability of a range of options for reform and to give due weight to the strategic considerations derived from the Terms of Reference.

The strength of the evidence in this report has been assessed based on standard methods of triangulation. Information received during the Review was classified as 'qualitative evidence' if it became a theme that recurred across several consultations. One-off comments made in a single consultation did not meet this criterion. The evidence was regarded as strong if it was assessed as "dependable" or "consistent" (corresponding to the notion of "reliability" in quantitative research)

and “valid” . Consistency or reliability was assessed by verification of the information through examination of raw data, themes and process notes. Validity was assessed by reference to the international evidence, as well as to the broader context in which community health in NSW operates (see our first report).

## 4 Policy context

The *NSW State Plan* (NSW Government 2006) and the *NSW State Health Plan* (NSW Health 2007a) identify strengthening primary and continuing health care in the community as a key strategic direction for the state health system. Both plans focus on prevention and early intervention, integrated primary health care, GP access and services and programs targeting hospital avoidance, mental health, aboriginal health, chronic care and disability support and support for carers.

The *NSW Integrated Primary and Community Health Policy 2007–2012* outlines six priority areas for reform and development in the sector including integrated service planning, integrated service delivery, improved models of care, stronger partnerships, improved workforce capability and enhanced information management and research (NSW Health 2006). The accompanying *Policy Implementation Plan* outlines the major projects and service development strategies being implemented by Area Health Services, branches within the NSW Health Department and key partners such as the NSW Alliance to progress the policy (NSW Health 2007b).

NSW is rolling out and evaluating the HealthOne initiative as one model to promote integration between primary health care providers. HealthOne provides capital funding to establish real or virtual multidisciplinary primary health teams that combine the resources of general practice, community health and allied health services in shared facilities in rural and selected urban and regional areas. HealthOne has similarities to the South Australian Health Plus model, Queensland Health Precincts and GP Super Clinics where capital is being provided to colocated community health and private sector services.

The NSW Health Services Act 1997 (Section 10) defines the role of an area health service. Area Health Services have 15 functions as specified in the Act:

- (a) generally to promote, protect and maintain the health of the residents of its area,*
- (b) to conduct and manage public hospitals, health institutions, health services and health support services under its control,*
- (c) to give residents outside its area access to such of the health services it provides as may be necessary or desirable,*
- (d) to achieve and maintain adequate standards of patient care and services,*
- (e) to ensure the efficient and economic operation of its health services and health support services and use of its resources,*
- (f) generally to consult and co-operate (as it considers appropriate) with any one or more of the following:*
  - (i) the Health Care Complaints Commission constituted under the Health Care Complaints Act 1993 ,*
  - (ii) health professionals practising in its area,*
  - (iii) other individuals and organisations (including voluntary agencies, private agencies and public or local authorities) concerned with the promotion, protection and maintenance of health,*

- (g) to investigate and assess health needs in its area,*
- (h) to plan future development of health services in its area, and, towards that end:*
  - (i) to consult and plan jointly with the Department of Health and such other organisations as it considers appropriate, and*
  - (ii) to support, encourage and facilitate the organisation of community involvement in the planning of those services, and*
  - (iii) to develop strategies to facilitate community involvement in the planning of those services and to report on the implementation of those strategies in annual reports and to the Minister,*
- (i) to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services,*
- (j) to provide services to persons with whom it has contracted or entered into an agreement under section 37 (2),*
- (k) to administer funding for recognised establishments and recognised services of affiliated health organisations where that function has been delegated to it by the Minister under section 129,*
- (l) to provide training and education relevant to the provision of health services,*
- (m) to undertake research and development relevant to the provision of health services,*
- (n) to make available to the public information and advice concerning public health and the health services available within its area,*
- (o) to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.*

As this brief overview of the policy context highlights, community health services in NSW are being provided within a policy framework that, if translated into practice, should be resulting in a vibrant community health service that sits at the centre of NSW health services. However, as discussed below, this Review has identified a significant gap between the policy and the practice. This is a fundamental issue and is discussed throughout the remainder of this report.

## **5 Organisational context**

NSW Health is one of many agencies that have responsibilities for the health and well being of the people of NSW and for the delivery of primary and community health related services. At the national level, the Department of Health and Ageing and Medicare Australia have responsibility for funding and the payment of subsidies for general practice, medicines and a range of community aged care services.

At the state level, a range of government agencies have responsibilities that interface with community health. These include, but are not limited to, the departments of Ageing, Disability and Home Care, Community Services, Aboriginal Affairs, Police and Corrective Services.

NSW Health comprises the NSW Department of Health, Area Health Services, statutory health corporations and affiliated health organisations.

There are eight Area Health Services that are responsible for providing health services in designated geographic areas.

There are also a number of public health organisations that provide statewide functions or specialist health services:

- Ambulance Service of NSW
- Justice Health
- Children's Hospital at Westmead
- Clinical Excellence Commission
- The NSW Cancer Institute.

The Department of Health is organised as six main functional areas, with four Deputy Director Generals:

### **Strategic Development**

- Primary Health and Community Partnerships
- Mental Health and Drug and Alcohol Office
- Inter-Government and Funding Strategies
- Statewide Services Development

### **Population Health**

- Centre for Aboriginal Health
- Centre for Health Advancement
- Centre for Epidemiology and Research
- Centre for Health Protection
- Centre for Oral Health Strategy
- Office of the Chief Health Officer

### **Health System Performance**

- Clinical Quality and Patient Safety
- Clinical Services Redesign
- Demand and Performance Evaluation
- Health Services Performance Improvement
- Strategic Information Management

### **Health System Support**

- Asset and Contract Services
- Corporate Governance and Risk Management
- Corporate Personnel Services
- Employee Relations
- Finance and Business Management
- Legal and Legislative Services
- Nursing and Midwifery
- Shared Services
- Workforce Development and Leadership

Several sections within the department have responsibilities for various aspects of community health. The Primary Health and Community Partnerships section within the Strategic Development Division has a policy responsibility for community health but not an operational role. While it administers some special initiatives, it is not responsible for community health financing. Other key branches include the Mental Health and Drug and Alcohol Office and the Centre for Aboriginal Health.

The Area Health Services were last restructured in terms of their boundaries in 2005. Each of the new Areas was established with a standard management structure consisting of a Chief Executive and six executive directors (Clinical Operations, Population Health and Planning, Corporate Services, Clinical Governance, Nursing and Midwifery, Workforce). No standardised structure was established for community health. However, the Department requested Chief Executives to ensure that the management of primary/community health and chronic care functions be effectively incorporated into clinical operational management in the third tier of each Area Health Service. Since the establishment of the Areas, some variations in management structures have developed and the management structure of each Area as at October 2008 is included in Attachment 4.

In addition to Area Health Services, the Department of Health provides grants to a range of NGOs for the provision of community health services. As discussed in Section 2, these are outside the scope of the current Review.

## **6 Contemporary national developments**

This Review is being undertaken at a time when significant initiatives are occurring at a national level. Not only is the next Australian Health Care Agreement (AHCA) under negotiation, there are also a number of national reviews in place. This section briefly summarises key developments that are expected to have an impact on community health.

### **6.1 National Health and Hospitals Reform Commission**

In February 2008, the Prime Minister and the Minister for Health and Ageing announced the establishment of the National Health and Hospitals Reform Commission (NHHRC). Its role is to provide advice to the Commonwealth on performance benchmarks and practical reforms to the Australian health system that can be implemented in both the short and long term.

The Commission is due to report in June 2009 on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:

- (a) “reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;
- (b) better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
- (c) bring a greater focus on prevention to the health system;
- (d) better integrate acute services and aged care services, and improve the transition between hospital and aged care;
- (e) improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
- (f) improve the provision of health services in rural areas;
- (g) improve Indigenous health outcomes; and
- (h) provide a well qualified and sustainable health workforce into the future”.

Its first report, *'Beyond the Blame Game: accountability and performance benchmarks for the next Australian Health Care Agreements'* was delivered in April 2008.

That report flagged the intention of the Commission to recommend the assignment of specific accountabilities to each tier of government. Specifically, the Commission proposed that states be accountable for public hospitals, mental health, maternal and child health and public health. The Commonwealth would be accountable for primary care ('all other aspects of care in the community, primary medical care and community health care', NHHRC 2008, page 4), prevention, aged care and indigenous health.

*The assignment of accountabilities for performance benchmarks does not mean that we are suggesting that there should be an immediate transfer of functions between governments where they differ from the current situation. The accountable government does not have to be directly involved in service delivery and there are likely to be advantages in retaining mixed provision of services by public, private and non-government agencies. Nor are we suggesting that any financial support for a function should only come from one government: support for public hospitals (or primary care services) could still come from both Commonwealth and states, but the contributions of each would be clearly specified (for example, as a share of funding or the volume of services purchased).*

*What we are suggesting is that one government should be held accountable by the public for overall service performance in each area. Australians want to move beyond the blame game with each level of government blaming the other for system failings. Patients and the public need to know to whom they can turn for accountability and redress.*

*Importantly, we are signalling our view about the desirable direction of the Commonwealth taking a more active role in ensuring adequacy of the full range of primary health care services. This would involve moving beyond general practice to allied health, district nursing, community mental health services and community health services, for example. We believe that there needs to be significant investment in primary health care infrastructure, an objective that the Commonwealth Government has partially set out to address through the establishment of GP Super Clinics. State governments have also responded to this challenge through major programs such as GP Plus in South Australia, HealthOne in New South Wales and Primary Care Partnerships in Victoria. But there is no integrated plan for the development, resourcing and networking of state-based primary health services, general practice and other private or non-government primary health services. (NHHRC 2008 page 22).*

In arguing for a more structural approach to reform, Dwyer and Eagar (2008) challenged this proposal, as others are now doing (albeit for different reasons):

*The Commission's proposal that the nominated level of government accept accountability for the relevant sectors without the matching authority is an expedient but we think unsustainable arrangement, requiring the development and maintenance of sophisticated monitoring and financial incentive systems. As the Commission acknowledged, the other problem is that it is technically difficult to separate some of the identified sectors. For example, how can responsibility for maternal and child health not be part of primary care? And how can mental health be separated from community health? While the Commission's proposals would no doubt solve some problems, others would inevitably be created and new blame- and cost-shifting possibilities would be opened up. This is consistent with Leutz's third law – 'Your integration is my fragmentation' (Leutz 1999:91) (Dwyer and Eagar 2008, p. 8)*

By November 2007, the NHHRC had commissioned 14 discussion papers on possible areas of reform. The target audience for these papers is the Commission itself, with each paper outlining various options for the NHHRC to consider. Seven of these papers deal with primary and community health and are of direct relevance to this Review, as is the paper on structural options for the reform of Commonwealth State governance arrangements. There are a further five papers

that deal with various aspects of prevention and health promotion that are also of relevance to this Review plus one paper on public private mix.

The issues covered in this series can be inferred by their titles:

### **Commonwealth State governance**

Options for reform of commonwealth and state governance responsibilities for the Australian health system

### **Prevention**

A national agency for promoting health and preventing illness

A Preventative Priorities Advisory Committee and Prevention Benefits Schedule for Australia

Financial incentives, personal responsibility and prevention

Funding policy options for preventative health care within Australian primary health care

New and emerging nurse-led models of primary health care

### **Primary and community health**

New models of primary and community care with a focus on rural and remote care

New models of primary and community care to meet challenges of chronic disease prevention and management

Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform

Achieving a patient-centred, effective, efficient, robust and sustainable primary and community care sector 2020

A vision for primary care: funding and other system factors for optimising the primary care contribution to the community's health

Primary care reform options

Models of primary and community care in 2020

### **Public private mix**

A mixed public private system 2020

The content of relevant papers in this series is considered in our compendium report on the literature. In terms of workforce issues and themes about reform options and service gaps in the field, the NHHRC commissioned consultations with health workers at the frontline and an outcomes report was produced (Elton Consulting 2008).

## **6.2 National primary care strategy**

In June 2008, the Minister for Health and Ageing announced that a National Primary Health Care Strategy will be developed. The Strategy will 'look at how to deliver better frontline care to families across Australia', with priorities including:

- Better rewarding prevention.
- Promoting evidence-based management of chronic disease.
- Supporting patients with chronic disease to manage their condition.
- Supporting the role GPs play in the health care team.
- Addressing the growing need for access to other health professionals, including practice nurses and allied health professionals like physiotherapists and dieticians.
- Encouraging a greater focus on multidisciplinary team-based care.

A review of the Medicare Benefits Schedule enhanced primary care items is also being undertaken alongside development of the Strategy with a focus on reducing red tape for doctors, simplifying the Medicare schedule, and giving more support to prevention. An External Reference Group is

supporting the development of the Strategy, which (like the NHHRC strategy) is expected to be completed in June 2009.

A discussion paper (*Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government*) was released on 30 October 2008 (Commonwealth of Australia 2008). It proposes ten key elements that 'could underpin a future Australian primary health care system':

***All Australians should have access to primary health care services which keep people well and manage ill-health by being:***

- 1. Accessible, clinically and culturally appropriate, timely and affordable;*
- 2. Patient-centred and supportive of health literacy, self-management and individual preference;*
- 3. More focussed on preventive care, including support of healthy lifestyles;*
- 4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing, and complex conditions.*

***Service delivery arrangements should support:***

- 5. Safe, high quality care which is continually improving through relevant research and innovation;*
- 6. Better management of health information, underpinned by efficient and effective use of eHealth;*
- 7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models.*

***Supporting the primary health care workforce are:***

- 8. Working environments and conditions which attract, support and retain workforce;*
- 9. High quality education and training arrangements for both new and existing workforce.*

***Primary health care is:***

- 10. Fiscally sustainable, efficient and cost effective.*

This discussion paper does not include specific proposals. However, there is a discussion under each element asking the question 'where could changes be made?'

### ***6.3 National prevention taskforce***

In April 2008, the Minister for Health and Ageing announced the establishment of a new National Preventative Health Taskforce. In announcing the Taskforce, the Minister also announced that the Commonwealth was committed to ensuring that preventative health measures become a key part of health funding agreements between the Commonwealth and state and territory governments.

The taskforce is to provide evidence-based advice to governments and health providers on preventative health programs and strategies, focusing on the burden of chronic disease currently caused by obesity, tobacco and alcohol.

By July 2008, the Taskforce is to provide advice on the framework for the Preventative Health Partnerships to be included in the Australian Health Care Agreements between the Commonwealth and the states and territories.

## **6.4 National maternity services review**

This Review is intended as the first step in developing a comprehensive plan for maternity services into the future and to inform the development of a National Maternity Services Plan. It is being led by the Commonwealth Chief Nurse and Midwifery Officer, Ms Rosemary Bryant. The Review covers antenatal services, birthing options, postnatal services up to six weeks after birth, and peer and social support for women in the peri natal period. A report to the Minister for Health and Ageing is expected by the end of 2008.

## **6.5 National performance indicators**

In June 2008, the Australian Institute of Health and Welfare (AIHW) proposed 40 national performance indicators for inclusion in the next Australian Health Care Agreement (AIHW 2008). In many ways, these suggested indicators reflect the range of issues on the current national agenda.

In summary, the AIHW has proposed:

- 15 performance indicators that are relevant to public hospitals and 14 to private hospitals
- 24 performance indicators that are relevant to primary care and community health
- 7 performance indicators that relate to public health activities
- 10 performance indicators that relate to aged care.
- 6 performance indicators that relate to maternal and child health services.
- 7 performance indicators that relate to mental health services.
- 6 performance indicators that relate to dental health services.

In some cases, there are multiple measures for the one indicator, resulting in 68 measures in total. These measures are summarised in Attachment 1.

While most indicators relevant to public hospitals are already being collected, the adoption of this performance indicator set would have significant implications for community health in NSW and for the community health information system development that is currently being planned.

## **6.6 Conclusion**

As the above summary highlights, this Review is being undertaken against a very fluid environment at the national level. The key aspects of the next AHCA are expected to be agreed at around the same time as our final report in December 2008, with the results of the various national reviews/strategies expected in mid-2009. The net result is that proposals in our final report will need to be considered in the context of subsequent recommendations and commitments made at a national level.

## 7 Range of community health services and current investment

### 7.1 Findings from the 2008 audit of community health services

In early 2008, NSW Health conducted an audit of its community health services (NSW Health 2008). Key findings from that audit are described in this section.

In 2004/05, NSW residents received almost 61 million primary and community health services, compared to 2.2 million hospital services. Of these 61 million services, 60% (36.2 million) were provided by General Practitioners and 40% (24.5 million) were provided by community-based services and hospital outpatient departments provided through the public health system NSW Health 2008).

As shown in Table 1, community health provides around eight to nine million occasions of service a year. Total services increased by 8.2% between 2004/05 and 2005/06 before decreasing slightly in 2006/07.

**Table 1** *Community health occasions of service 2004-2007*

Year	Community health occasions of service
2004/2005	7,968,188
2005/2006	8,622,748
2006/2007	8,619,186

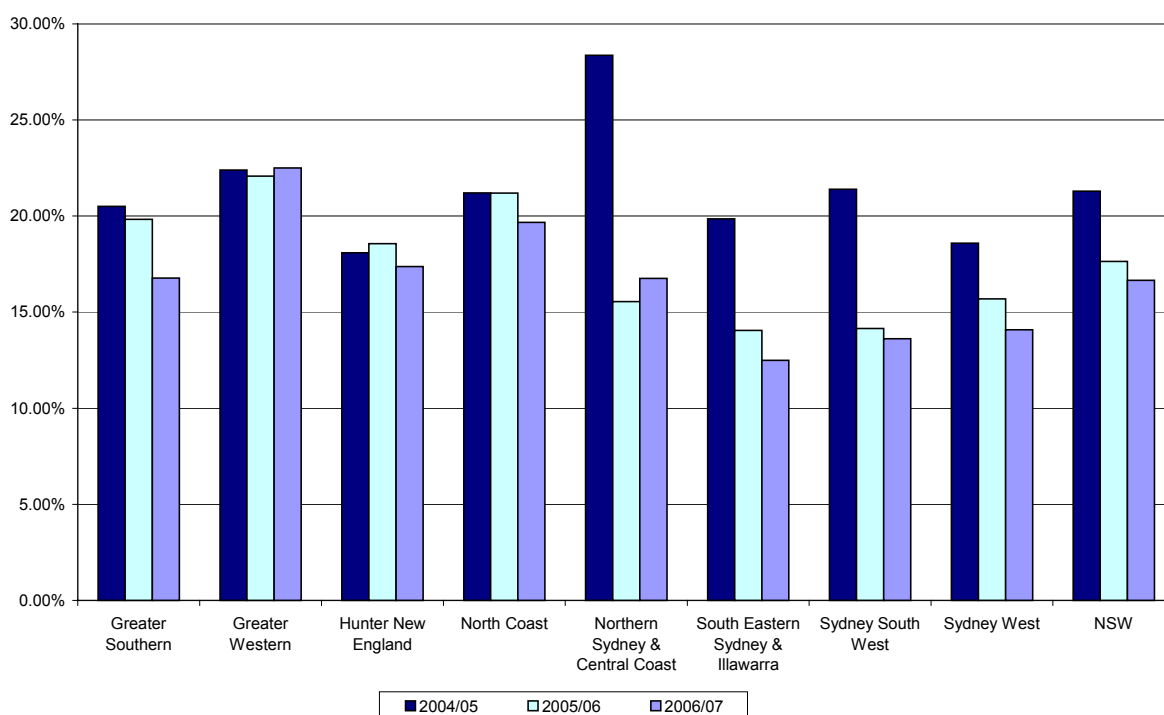
Source: NSW Health 2008

The eight million community health services in 2004/05 were provided by 12,739 FTE staff. In 2006/07, a total of 13,584 community health FTE staff were employed, a 7% increase in the two year period.

Nevertheless, the audit found that the number of staff employed in community health declined as a percentage of total staff from 21.3% in 2004/05 to 16.7% in 2006/07 (see Figure 1). This decline occurred across most areas. In 2004/05, more than 18% of staff employed in all areas worked in community health. By 2006/07, only two areas (Greater Western and North Coast) employed more than 18% of total staff in community health.

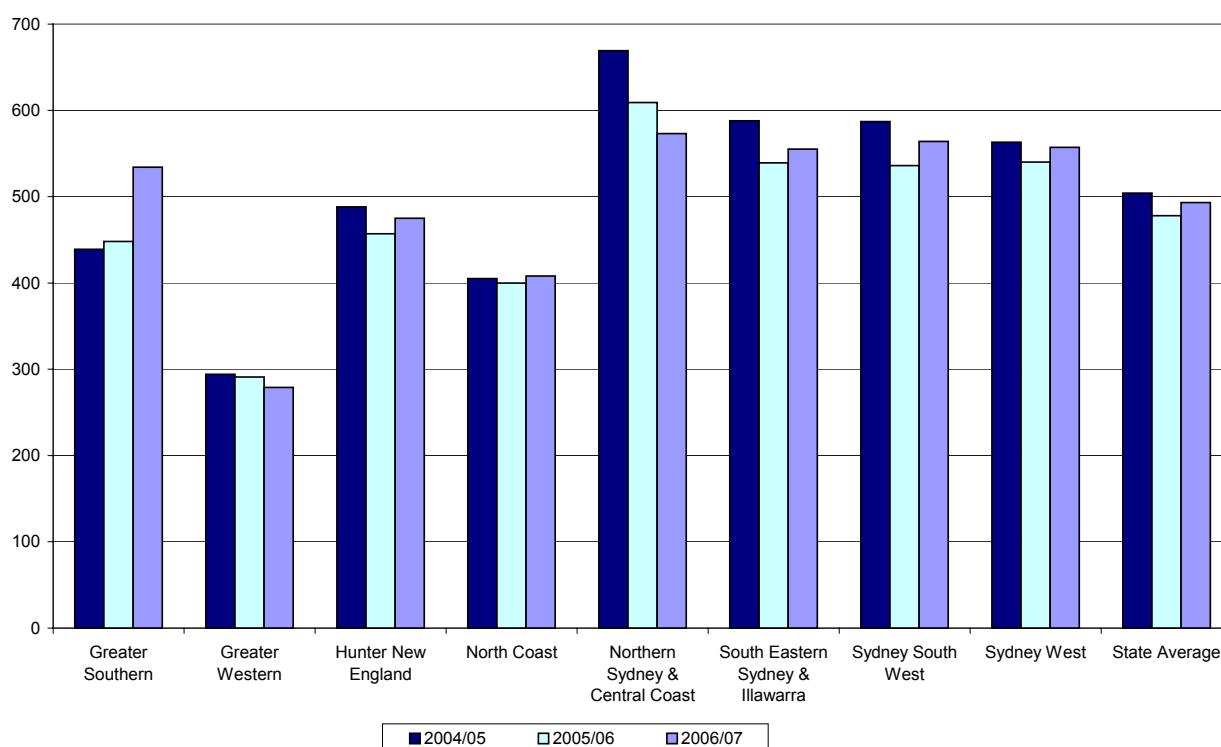
The field consultations indicated that some of this decline is due to changes in how services are organised. Specifically, we have been informed that some services have been moved from community health to either population health or to various clinical streams. That said, evidence from the consultations also suggests that this is not the sole explanation for the decline in staff numbers, with some of the decline reflecting a genuine reduction in community health staff in the three year period.

**Figure 1** *Percentage of staff employed in community health by Area Health Service*



With the exception of two areas (Greater Western and North Coast), the number of community health staff also declined on a per capita basis (see Figure 2). The biggest decline (14.3%) occurred in Northern Sydney and Central Coast.

**Figure 2** *Community health staff per capita*



This finding is consistent with patterns of financial investment in recent years. NSW expenditure on community health increased from \$1.2 billion in 2004/05 to \$1.5 billion in 2006/07. Despite this reported increase, overall expenditure on community health declined as a percentage of total

expenditure from 18.0% to 14.5% over the same period. This is due to significant increases in hospital budgets over the same period.

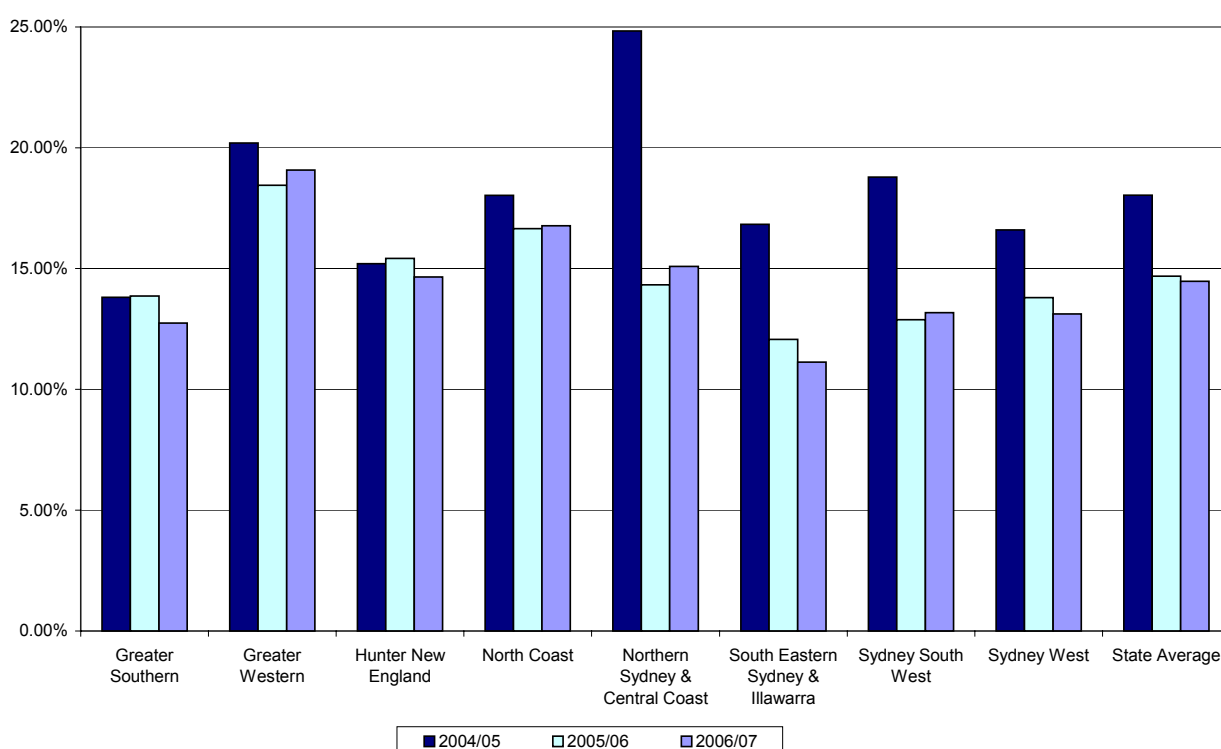
This pattern was also found when funding for admitted patient services was excluded. Each year community health has been receiving a smaller proportion of funding allocated to non-admitted services, with funding for community health declining by 5.8% relative to other non-admitted services.

In 2004/05, all areas except for Greater Southern spent more than 15% of their total budget on community health. By 2006/07, only three areas (Greater Western, North Coast and Northern Sydney and Central Coast) spent more than 15% of their budget on community health. The lowest levels of community health expenditure are in Greater Southern, South Eastern Sydney and Illawarra and Sydney West.

The audit found significantly different levels of community health investment across areas, with Greater Western spending more money per capita on community health (\$375 in 2006/07) than the other areas. At the other extreme, Sydney West spends the least (\$187 in 2006/07), with spending in Sydney West representing less than half that spent in the Greater West.

While there were some methodological difficulties with the audit, the overall findings raise serious questions about the balance of health investment in NSW. The results also raise serious questions about equity of access to community services across the state.

**Figure 3** *Community health as a percentage of total Area Health Service expenditure*



## 7.2 Range of community health services currently provided in NSW

Figure 4 below summarises the range of services typically provided in the community. However, not all of these services are provided in all Areas and, as discussed in Section 8 (page 28) there are differences between Areas in terms of how these services are organised and governed.

A final issue in considering this table is that there is no standard classification of community health services and no standard nomenclature. For the purposes of convenience, we classified services into five broad program types, each of which consists of a number of streams:

- Intake and initial assessment
- Child and family health services
- Rehabilitation, aged care and chronic disease
- Community and population services
- Services for priority population groups

It is important to stress that these are services that a client/patient may need, not different specialist teams. While some services may be provided by specialist teams, many are delivered by generalist community and primary health staff within a multidisciplinary model.

However, just as acute care has its own classification systems such as Diagnosis Related Groups, there is a need for a standard classification of community health. This is discussed further in Section 9.4.

All of these are core issues for this Review and are discussed further in the remainder of this section and in Section 12.

**Figure 4** *Summary of community health services provided in NSW*

Stream	Examples of services typically provided by community health
<b>Intake and initial assessment</b>	
Intake and initial assessment	Intake
	Initial needs identification and referral
<b>Child and family health services</b>	
Child and family	Early childhood health
	Families NSW
	Family Care Cottages
	Community midwifery
	Paediatric therapy services
	Disability diagnosis and assessment
	School health
	Immunisation
	Genetic counselling
Physical Abuse and Neglect of Children	Therapy, counselling and casework services
	Education and training
<b>Rehabilitation, aged care and chronic disease</b>	
Aged & Extended Care	ACAT
	Dementia support
	Falls prevention
	Day programs
	PADP
	Home assessment
	Medication review
	ASET and hospital liaison
Community Nursing and Domiciliary Care	Domiciliary care
	Wound management

Stream	Examples of services typically provided by community health
	Health assessment
	Health maintenance
	Primary palliative care
	Specialist nursing services in areas such as breast care, renal care, stoma and continence
Community Rehabilitation	Such as brain injury, cardiac, stroke and orthopaedic
Hospital Demand Management	Community Acute/ Post Acute Care
	Hospital in the home
	Discharge planning & coordination
	ComPacks
	Transition care
Multidisciplinary Chronic Disease Management	Examples of which include cardiopulmonary and diabetes education and control
Palliative Care	
<b>Community and population services</b>	
Counselling & psychosocial services	
Drug and Alcohol	Assessment and counselling
	Home detoxification
	Opioid replacement programs
	Needle and syringe
	Drug Court
Health Promotion	Disease prevention and risk factor programs
	Injury prevention
	Community nutrition
	Health promoting schools
	Mental health promotion
	Community development
Mental Health	Child and adolescent
	Adult mental health
	Older people's mental health
	Special needs
Oral Health	School Dental Program
	Adult Dental Services
	Specialist Services
	Dentures
Sexual Assault	Crisis care and medical examinations
	Counselling
	Court support and advocacy
	Education and training
Sexual Health	HIV/AIDS programs
	Clinical services
	Contact tracing
<hr/>	
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Stream	Examples of services typically provided by community health
	STI education and awareness
<b>Services for priority population groups</b>	
Aboriginal Health	Aboriginal Health Workers
	Priority programs – otitis media, eye health, maternal and infant health, renal etc
Multicultural Health	Ethnic Health Workers
	Interpreter services
	Refugee health
	Torture and trauma services
Women's Health	Cervical cancer screening
	Reproductive health information and education
	Priority target group programs and capacity building
Youth Health	Youth health services
	Education and support programs
	Interagency and capacity building

### 7.3 Sufficiency of community health services currently provided in NSW

This issue is inherently linked to the issues of allocative efficiency and the role of community health discussed later in Section 11 (page 50). As already stated, this is a strategic and not an operational review and our Terms of Reference do not include reviewing the adequacy of existing services. However, we received extensive comments in the consultations about the insufficiency of existing services and many of these are of strategic importance.

As discussed elsewhere, short-term hospital demand management services have been increasing at the expense of other services in the community, particularly prevention and early intervention. The Review received consistent feedback on the shortage of psychosocial counselling (particularly in metropolitan areas) and youth health services, as well as the limited capacity to sustain home visiting for high risk families everywhere. There are very limited evidence-based early intervention programs for young people with early onset psychosis and other mental health problems. There is also limited access to allied health treatment, with many people simply assessed and put on long waiting lists.

A further and related issue is the trend to establish more tightly defined micro programs, each with their own eligibility criteria and narrowly targeted recipients that limit the capacity of community health services to flexibly respond to local needs. These issues and their related themes are consistent with finding reported about national concerns under consultations with frontline staff commissioned by the NHHRC (Elton Consulting 2008).

These strategic issues are considered in the final report of the Review.

### 7.4 Good practice models in the field

Contributors to the Community Health Review were invited to provide examples or case studies of good practice in the field to inform the Review. Numerous examples were provided including models for specific services or programs and examples of service or system redesign to improve access or efficiency.

A sample of these case studies that provide a snapshot of the kind of innovation and practical problem solving that is occurring in the field is reported in Attachment 2. This is not a comprehensive audit of innovative primary and community health activities. Models across NSW and further examples are included in this report in the section on quality and safety (Section 9.3).

Some of the models or services in scope are large scale programs or service redesign initiatives that have been researched and formally evaluated. But these are in the minority. This reflects the lack of investment in primary health care research and development and in systematic clinical redesign outside hospital or hospital community interface settings. The majority are case studies of local or Area initiatives that have been documented and assessed locally and illustrate a commitment to service improvement, better targeting of priority groups or smarter service delivery.

### **7.5 Hospital demand management**

A key theme throughout the Review has been the growing need for hospital demand management services and how these are best provided. We consulted the Review Steering Group on this specific issue. There was no support among the Steering Group for community health to be defined as primarily a short term hospital demand management strategy. That said, there was no consensus on how hospital demand management is best organised and delivered, with some members believing that it is best managed by community health and others believing that it is best managed by hospitals.

There is clear evidence and agreement from all quarters, including the NSW Auditor-General (2008), on the increasing need for more effective hospital demand management that is designed to prevent avoidable admissions, to facilitate early hospital discharge and to reduce the rate of hospital readmissions. But that does not mean that this role is best undertaken by community health.

The mixed views of the Steering Group on this issue are consistent with our broader field consultations. As one example of this, of 72 respondents to the on-line survey, 47% believed that hospital demand management is best undertaken by community health, 17% by hospitals and 36% were not sure.

Those advocating for this role to be the responsibility of community health argue that community health already has the expertise and the necessary linkages with general practitioners and other community care providers who are essential partners in effective hospital demand management. A further argument supporting this position is that, at least at present, the role of community health in hospital demand management is the only lever that community health has to engage with area management and clinical networks.

Those advocating the alternative position point to recent history where the requirement for hospital demand management has resulted in a disinvestment in prevention and early intervention. In the absence of a circuit breaker, there is a view that the only way to maintain any real investment in prevention and early intervention is to quarantine it from hospital demand management. Giving hospitals the responsibility for managing their own demand is a way to quarantine funding for services that have a longer term agenda.

This is a key issue that will be addressed in our final report.

### **7.6 The balance between specialist and generalist services**

There has been an increasing trend towards the establishment of specialist teams within community health in recent years and a strategic issue for the future is the balance between primary and specialist services. The majority view of the Steering Group was that community health should have a strong generalist core supplemented by a small number of specialist programs.

There is no consensus in the field on this issue. While many people shared the view that there needs to be a strong generalist base, many of the examples of best practice we received came from small specialist teams that have established their own data collection and evaluation

systems. They pointed to the good outcomes that they are achieving and the need to expand such programs.

In its submission, the Council for Intellectual Disability (CID) pointed out that the numbers of people requiring rehabilitation because of their intellectual disability are very low. However as they live their lives and age like everyone else, they may have rehabilitation needs. CID stated that these needs should be met as part of mainstream services, and the requisite speciality input is about intellectual disability as well as rehabilitation. CID proposed that a multidisciplinary intellectual disability Health Resource Team should be established in each Area Health Service with a network of clinical nurse consultants focused on the health of people with intellectual disabilities.

*'One issue we should comment on further is the possible role of rehabilitation services in the health care of people with intellectual disabilities. For reasons set out in our response to the NSW Health Discussion Paper (NSW Health 2007a), we are very clear that we do not support the suggestion that these services should become the base for the state-wide network of intellectual disability specialist health services. (Submission to the Review from the NSW Council for Intellectual Disability.)*

The Review received a number of submissions calling for the establishment of more specialist teams. While the following is not a comprehensive list, it illustrates the range of specialist services that have been proposed:

- Multidisciplinary intellectual disability 'Health Resource Teams' in each Area Health Service
- Specialist teams for very low prevalence disorders such as Spina Bifida
- Specialist domestic violence services throughout NSW in a similar manner to the introduction of Sexual Assault Services.
- Specialist resources for psychosocial services in community health centres
- Specialist services for survivors of domestic violence and child abuse
- Specialist falls prevention teams to target at-risk groups.
- Community Aged Care and Chronic Disease Services led by a Community Geriatrician / Physician that would work closely with local GPs.
- Specialist HIV services with an emphasis on chronic disease management
- Mobile facilities for specialist services in rural and remote areas to treat chronic diseases and to support generalist workers
- Specialist men's health services to address psychosocial, domestic violence and intergenerational issues.

At least in part, the increasing trend towards establishing specialist teams within community health is due to the inclusion of components of community health services within hospital, sector or area clinical streams. This is particularly the case for community health services located in those areas that have principal referral hospitals, with the specialist teams in the community reflecting the sub-specialist structures of the hospitals or through the role of population health.

*'The multidisciplinary community health team provides community health care services for people living with HIV/AIDS (PLWHA) across the geographical area of SESIH. The service reports to the HIV and Related Programs (HARP) Unit1 under the Population Health Stream with clinical governance provided through the Clinical Stream Director Population Health and Primary Health Care. Strategic alignment is also provided through the Area Director of Primary and Community Health.'* (Submission to the Review from the Area-wide HIV Community Team, South Eastern Sydney Illawarra Health)

The other argument in favour of increasing the number of specialist services is essentially industrial. Recent award changes have favoured specialist clinicians over generalists in their

criteria for promotion. Many staff perceive that they need to become a 'specialist' for reasons of both career development and remuneration. This is not an issue that is easy to solve and is similar in many ways to the situation with general practice.

That said, the arguments in favour of maintaining a strong generalist model are equally strong and they are not restricted to NSW. As our accompanying evidence report demonstrates, there is good evidence to suggest that generalist primary care services can effectively deliver a wide range of services (but not all) along the full spectrum from prevention to continuing care. General practitioners and other referral agencies have pointed to the difficulty they have in attempting to navigate a community system that is increasingly specialised. For rural communities, a strong generalist service can deliver a range of services locally without the need for consumers to travel long distances to access specialist services. From an efficiency perspective, the generalist model is more cost effective in cases where it can be demonstrated that health outcomes are similar.

Contemporary debates about the role of generalist teams versus specialist services internationally emphasise the origins of the apparent dominance of the specialist models.

*'Primary health care was declared the model for global health policy at a 1978 meeting of health ministers and experts from around the world. Primary health care requires a change in socioeconomic status, distribution of resources, a focus on health system development, and emphasis on basic health services. Considered too idealistic and expensive, it was replaced with a disease-focused, selective model. After several years of investment in vertical interventions, preventable diseases remain a major challenge for developing countries. The selective model has not responded adequately to the interrelationship between health and socioeconomic development, and a rethinking of global health policy is urgently needed.'* (Magnussen et al. 2004)

This debate of comprehensive versus selective primary care was well summarised for the Australian context by Gunn et al (2007) in their recent review of 'generalism' in primary care who describe *'the sense of urgency and alarm in...much of the international literature about the devaluation, loss and downfall of generalism within primary health care systems'*.

*'Some of these (issues) relate to the way in which generalism has always been measured in opposition to specialism with specialists being seen as advanced or more expertly trained. Others relate to political and economic forces which have pushed technical focus and specialism over generalism. It is striking that generalists, the people who provide first contact, continuous care in relation to the social context of individuals and communities have had to justify and define their roles so much.'* (Gunn et al 2007 p.21)

*'The values and kind of care delivered through generalism do provide the basis for an equitable, accessible and affordable health care system.'* (Gunn et al, 2007, p.33)

In determining the right balance between specialist and generalist services, there are a number of issues to consider:

- The allocative and dynamic efficiency of the overall health system (see the compendium evidence report for a discussion on this issue)
- Projected workforce shortages
- Career development and promotion opportunities for staff
- How best to deliver services to consumers with commonly occurring chronic and complex conditions whose needs cross more than one speciality
- How best to deliver services to consumers with high needs but with very low prevalence disorders or disabilities
- The interface between community health speciality programs and key partners such as general practitioners
- The different needs in urban and rural areas.

A number of submissions to the Review saw no conflict at all between generalist and specialist models, pointing out that:

*'the local community health centre could provide a very valuable ongoing support service to young people with high support needs and significantly improve their health care and quality of life... A health worker in each community health centre with a special interest in young people could develop some expertise in these areas, network with primary and tertiary health providers, provide some case work and run support groups.'* (Submission to the Review from Dr Carolyn West, Director Spina Bifida Unit, The Children's Hospital at Westmead)

*'This is not an argument for the separate identity and provision of community based health care, but for resetting the balance between hospital and community components of integrated health services, and shifting the centre of gravity of such services towards more accessible community health services.'* (The Future of Community Health Services in Australia, submission to Review from Alan Rosen, Roger Gurr & Paul Fanning)

The right balance between community and hospital and between generalist and specialist services cannot be determined in isolation but is part of a set of bigger issues about the role of community health services and where they fit within the broader NSW Health system. This issue is addressed in our final report.

## **7.7 Summary of issues and tensions**

The evidence from the Review is that community health investment has decreased on a relative basis over the last several years while the need for hospital demand management has increased. At the same time, the consultations received the consistent message that community health staff perceive that they are expected to provide a comprehensive range of services that they are not resourced to provide. In practice, this dilemma has been addressed by meeting the requirement for hospital demand management at the expense of prevention, early intervention and psychosocial services.

With the exception of the specific issue of hospital demand management (see Section 7.5), there is a majority view among the Steering Group on the role of community health. Almost all members agree that community health should provide the full range of services from prevention to palliation.

This is consistent with views of many key stakeholders consulted both in interviews and in the on-line survey, as well as consultations undertaken in the national context and commissioned by the NHHRC:

*'To reduce the burden on hospital infrastructure and resources, a 'big picture' re-think about the role of hospitals and role of primary health centres/clinics is needed. Such a re-think should set out to move services out of hospitals and integrate community-based primary care and acute care services to provide a more holistic healthcare system. It could result in new or reshaped healthcare providers located at schools, GP clinics or visiting the patient at home ... This approach would require an increase of funding for community and home-based care.'* (Elton Consulting 2008, p.22).

However, a recurring theme in the consultations has been the need to reach agreement on a set of core programs that are evidence based and measurable with key performance indicators that Chief Executives can own and be judged by. In the same way that key performance indicators for emergency department access performance and surgery have given resource priority to emergency departments and elective surgery, key stakeholders have identified this as a key strategy to drive the future role and resourcing of community health.

Implicit in proposals to define a core role for community health is an assumption that at least some of what community health services currently do is of low priority, and can be abandoned for other sectors address, in favour of a set of core services that are more effective. The review of the

international evidence commissioned as part of the current Review was designed to inform this issue and the conclusion there is that there are few solid facts to guide a strategy that involves selective disinvestment. The future role of community health is discussed further in Section 11 and the final report in this series addresses this issue in some detail.

## 8 How community health in NSW is structured and managed

Primary and Community Health Services are managed and structured differently in each Area Health Service with different models operating in predominantly metropolitan, mixed urban and rural and rural areas and differences the role, responsibilities and level of seniority of staff with the primary and community health portfolio responsibilities.

There are also ongoing internal changes in some the Areas where previous structures and models from the amalgamated areas have not been fully reconciled on the ground following the Area Health Service amalgamations in January 2005.

Attachment 3 provides a brief summary of how community health is managed in each Area Health Service while Attachment 4 shows the organisational charts for each Area Health Service as at October 2008.

In summary, most Areas are in a continuing process of restructuring where the new structures are driven by planning in some instances but primarily by workforce pressures and competing service delivery demands. Whilst there are good practice models of community health and primary care, these are not universally integrated, nor do they completely align with population health needs.

The factors that continue to drive decision-making about structures are mainly economic, administrative and historical, with award structures, inter-professional competition and acute care demand management being most salient. In this context, it is not surprising that there is a widely perceived mismatch between State and NSW Health policies and directions and the capacity of community health and primary models of care to deliver the expected outcomes.

### 8.1 *Structure and governance models*

All Areas have implemented a localised version of geographic networks or cluster services with a Cluster or Network General Manager with delegated operational management and budget responsibilities for local hospitals. In all Areas, administrative arrangements aim for more integrated hospital and community health services.

All Areas have also implemented a localised model of clinical streaming that brings together clinicians from across the Area to provide strategic advice and leadership on clinical practice and service development for clinical services in defined specialities across the Area. There are variations across the Areas on the dimension of whether stream coordinators have advisory and clinical governance versus line management responsibilities.

In the interests of attempting a useful classification of structures the following sections describe four broad governance and organisational models for primary and community health services operating in NSW. Each model has its own structural and functional characteristics, span of control and reporting arrangements and a single model does not necessarily apply across an entire Area Health Service:

- Area wide primary and community health service with budget and line management
- Area primary and community network model
- Integrated health service with area primary and community care program
- Rural area community health policy unit or directorate.

#### 8.1.1 **Area wide primary and community health service with budget and line management**

Area wide primary and community health services that have line management and budget holding responsibilities for multidisciplinary, multi program primary and community health services are

operating in Sydney South West and in Sydney West Area Health Services. There are similarities and differences between the models in place but they share a range of common features and operational and governance characteristics.

Sydney South West and Sydney West are both predominantly metropolitan Area Health Services (with smaller semi rural communities on the periphery) with populations of over 1.2 million people that are experiencing strong population growth. They serve diverse communities with older established populations in the centre and inner ring western suburbs and in the rural areas and major urban growth corridors with high birth rates and a younger age profile.

Both Areas have large Aboriginal and Torres Strait Islander communities and large multicultural populations and attract significant numbers of refugees and new settlers. Both Areas also include LGAs with high levels of socioeconomic disadvantage and high health need related to low income, higher unemployment, lower levels of educational attainment, high child protection notification rates and high reported rates of violence.

Hospital services in both Areas have been upgraded over the last fifteen years to keep pace with population growth or ageing with major redevelopments or upgrading of teaching hospital facilities at Liverpool, Nepean, Concord and Westmead and redevelopment or upgrades of general hospital and mental health facilities at Blacktown/Mt Druitt, Campbelltown, Fairfield, Auburn, Bankstown, Hawkesbury, Blue Mountains, Lithgow and Cumberland Hospitals.

Both Areas have a mix of freestanding and hospital based community health centres and early childhood centres and provide outreach services to other locations. There are also community controlled Aboriginal Health Services in both Areas, and a range of non government health and related human service agencies funded by DoCS, DADHC, NSW Health and the Commonwealth that interact with Health on whole of government initiatives and programs such as Families NSW.

### **Characteristics of area wide Primary and Community Health Services**

The area wide primary and community health service models operating in SSWAHS and SWAHS share a range of common governance and structural characteristics. These are defined operational budgets with explicit performance targets and dedicated staffing and a senior Primary and Community Health Director or General Manager. They have similar roles and standing in relation to the Area Executive as hospital managers and have small clinical support units that provide financial management and reporting, quality and risk management, mandatory training and placements, informatics and support for policy and procedure development for the Area.

Clinical services are grouped into major functional groupings:

- **Child and family health services** that are provided in localities across both Areas and include early childhood health services, Families NSW and integrated perinatal services, paediatric therapies and developmental assessment services and targeted psychosocial assessment and brief interventions for at risk parents and parents.
- **Community and specialist nursing and chronic and complex care services for adults and older people with complex and ongoing needs** are provided in both Areas but the model differs. The community nursing service in SSWAHS provides community acute and post acute care services for local hospitals. In SWAHS the PACC service is currently part of the Access and Patient Logistics Network but community nurses have a role in emergency department diversion through 'pulling' community health type patients identified on the central dashboard back into community care to avoid a hospital admission.
- **Specialist clinical services with an Area wide role** such as area diabetes or community nutrition services, sexual health and sexual assault and violence related services.
- **Specialised services or Area programs for priority population groups** including aboriginal health, women's health, multicultural health, youth health and locality based community development services in disadvantaged communities. In SSWAHS the specialist clinical and

population group services are managed in one clinical stream whereas they are managed as separate area streams in SWAHS.

These Areas have undertaken extensive service planning and system redesign as part of the development of the new Area model including review of the program resource base, defining core services and standardised interventions and models of care that will be provided within each clinical stream using the evidence, establishing central intake processes and building better interfaces and information feedback loops with GPs and with acute hospitals. Developmental work has also commenced in both Area services on planning tools and workload measures for key professional groups and services and on funding models.

### **8.1.2 Area Primary and Community Network Model**

Hunter New England Health has adopted an Area Primary and Community Network model that incorporates management and budget holding for community health services, a group of specialist Area-wide services and rural hospitals and local integrated health services. There is a parallel Area Acute Network that manages the nine major acute hospitals in the Area. The clinical operations management model is shown in Attachment 4.

Hunter New England Health serves a population of 840,000 people living in distinct metropolitan, rural and remote communities spread over 130,000 square kilometres and has the largest Aboriginal population in NSW. The Area has 67 hospitals and health facilities ranging from tertiary referral centres to multipurpose services and community health posts in small rural communities with population growth in the Hunter region and on the coast and stable or declining populations in many parts of New England.

The Primary and Community Network in Hunter New England has a defined operational budget, line management responsibility and performance targets for the hospitals, rural health services and community health services in scope. Sixty health facilities are managed through the Network.

There are 5 Divisions of General Practice in Hunter New England and shortfalls in the number of general practitioners available in rural and remote communities as shown in Attachment 3. There are 8 community controlled Aboriginal Medical Services and 3 other incorporated organisations in rural towns across the Area and in Greater Newcastle. There are government funded NGOs and human service agencies operating across the Area with the majority based in the major urban and regional population centres.

### **Characteristics of Area Primary and Community Network Model**

The Primary and Community Network is led by a tier 2 director who provides strategic leadership and oversees operational management for the Network. The position reports to the Area Director of Clinical Operations, is part of the senior operations executive team and has similar standing to the Director of Acute Networks.

The Primary and Community Network Director is also executive sponsor for a number of Area-wide specialist networks and administers area specialist services that have an integrated inpatient, ambulatory and community health focus or are predominantly community based. These include aged care and rehabilitation services, drug and alcohol services, the area diabetes service, oral health and genetics services. The Primary and Community Network organisation chart is shown in Attachment 4.

Within the network, operational management is delegated to eight Cluster General Managers who are responsible for hospitals (district, community acute and non acute and multipurpose services plus specialist sub acute facilities) and community based services within defined geographic areas. Larger hospitals and community health services have a Nurse Manager responsible for inpatient services and a Community Health Manager responsible for community teams. Smaller sites have a Health Service Manager responsible for both services. Community health services in

Armidale, Tamworth, Maitland and Taree also have a designated Community Health Manager responsible for budget and performance to the Cluster General Manager.

The structure of community health services and team structures varies across the Area and reflects the differing size and needs of the catchment populations in the urban, regional, rural and remote communities and workforce issues.

In Newcastle and the regional centres with base or major acute hospitals, such as Tamworth, Armidale, Taree and Maitland, community health provide a mix of generalist and specialist multidisciplinary services that typically include:

- Aboriginal health
- Aged care services including ACAT, community geriatric clinics and specialist assessment
- Child, family and youth health
- CAPAC
- Counselling and psychosocial support
- Generalist and specialist community nursing
- Multidisciplinary chronic disease programs in the community and linked to specialist services in the hospital
- Specialist drug and alcohol services
- Community mental health
- Community palliative care
- Services responding to violence including sexual assault, PANOC and domestic violence
- Oral health

In the medium and small rural communities, community health is generally staffed by a core of generalists who offer a range of programs and treat all age groups and a wide range of health problems supplemented by specialist workers and/or visiting services provided by regional centres or fly-in services. The services and typical staffing include:

- Community nurses with a mixed caseload including child and family health, aged care, maintenance and care of people with complex illness.
- Allied health professionals in a range of disciplines (primarily physiotherapy, occupational therapy, dietetics, speech pathology and psychology or social work dependent on workload and capacity to recruit) who typically work across inpatient, outpatient and community health settings
- Visiting or fixed dental services
- Some sites may have specialist workers in mental health, drug and alcohol or PANOC
- Some sites will have an Aboriginal Health Worker or Health Education Officer.

Remote communities generally have a small community health post which is staffed by a primary health care nurse who delivers a range of preventive, early intervention and treatment services for local residents including child and family health services and visiting teams.

Hunter New England also administers the Commonwealth Rural Health Program that provides access to mobile services and a focus on community capacity building.

A Community Health Peak Forum brings together all primary health care providers in Hunter New England Health to provide strategic direction for all community based services and act as a

clearing house and forum for development of recommendations to the Area on community health issues. It includes the Cluster General Managers, Aboriginal Health, Mental Health, Drug and Alcohol and Oral Health Directors with the Directors of Population Health and Planning, Clinical Governance and Nursing and Midwifery and portfolio managers with responsibilities for integration and partnerships and innovation and reform across the Area.

### **8.1.3 Integrated health service with area primary and community care program**

NSCCAHS and SESIAHS are examples of metropolitan Areas that have established an Area primary and community health or population health program model with line management responsibility for a suite of Area wide services. These sit alongside clusters or networks that provide integrated hospital and community health services for defined geographic areas.

Both Areas have Area clinical streams that provide advice on service planning and facility roles, clinical practice, workforce, performance and systems improvements, integration and resource use. The Mental Health and Drug and Alcohol Stream generally has budget holding and operational management responsibilities.

#### **Area primary and community health program model in NSCCAHS**

North Sydney Central Coast Area Health Service is a predominantly urban health service and has adopted a geographic model of service organisation with general managers with budget and operational responsibility for all hospital and community health services operating in Hornsby Kuring-gai, Northern Beaches, North Shore Ryde and Central Coast.

The Area has a primary and community care program model with an Area Director responsible for a series of Area wide services with discrete budgets. Primary and community care is one of eleven clinical streams in NSCCAHS that provide strategic and clinical policy advice to the Area and facilities. However the model is not firm and is continuing to evolve.

The Area Director of Primary and Community Care in NSCCAHS reports to the Director of Clinical Operations. The position has line management and budget responsibility for a series of Area wide programs and services including:

- Area acute post acute care
- Community nursing
- Chronic care program
- Oral health
- Breast screening
- HIV and related programs
- Multicultural health
- Women's health
- Age care programs
- Child protection and sexual assault
- Carer support

The Area Director also provides strategic advice to the general managers and the primary and community care services in each health service.

Primary and community care managers are part of the local health service executive and report to the locality General Manager. The service profile at local level varies across the Area. There is a core of child and family health services, visiting allied health and community nurse clinics and

health promotion activities operating in most health services plus visiting specialist services or collocated mental health and drug and alcohol services at several sites.

### **South East Sydney Illawarra Governance Model and Service Structure**

South East Sydney Illawarra (SESAHS) has adopted a matrix model that consists of three Hospital Networks (Northern, Central and Southern) through which the operational and day to day management of services primarily occurs. Each network is managed by a General Manager who is accountable for both hospital and community based services within that geographic region. Twelve clinical streams intersect the hospital networks and extend across the wider area health service. Each clinical stream has an Area wide Clinical Director and a full or part time Senior Nurse Manager.

Community health care services are delivered in a variety of settings across the area, including the home, community health centres and outreach centres for hard to reach groups. There are approximately 100 strategically placed facilities accessible to the community, varying in size from single rooms to large multipurpose buildings and are freestanding in a community location, attached or included in commercial facilities or on the grounds of a hospital. Only a very small number of facilities were purpose built and the majority are older style buildings.

Community health services in SESAHS are administered from seven geographic locations – Prince of Wales Hospital, St Vincent's Hospital, St George Hospital, Sutherland Hospital, North/Central Illawarra, South Western Illawarra and Shoalhaven. Within each of these locations, outreach and satellite centres are networked to a major centre. The major centres are role delineation level 5 or 6. The major centres and larger satellite centres are multidisciplinary centres, providing a range of different services covering many clinical streams. Services are holistic and work across many clinical streams and community clusters at the one time.

Many of these services are now part of the Population Health Division (including Health Promotion, Community Nutrition, Multicultural Health, Women's Health, HIV/AIDS and Related Programs (HARP) Unit, Homelessness Health and Youth Health Coordinator).

The Area Director of Primary and Community Health (PaCH) reports to the Area Director of Clinical Operations. The Director PaCH does not have line management responsibility for community health staff, but provides Area wide coordination, strategic leadership and policy advice. The Director works closely with the Hospital Network General Managers and all Clinical Stream Directors, particularly the Aged and Chronic Care/Community Health and Population Health Streams. The rural needs of the Shoalhaven region are supported through the Rural Health Directorate that focuses particularly on the service delivery issues unique to the rural part of SESAHS.

#### **8.1.4 Area community health policy unit or directorate**

Greater Western, Greater Southern and North Coast are rural Areas that have established Area policy units or an advisor role that provide leadership and service development support for primary and community health services that are managed in clusters and integrated health services and networks.

Greater Western and Greater Southern are vast rural Areas with dispersed communities, declining population in inland and remote areas and growth in regional inland centres and in the case of GSAHS on the south coast. Both Areas have large Aboriginal populations and indigenous people are 8.3% of the GWAHS population compared to 2.3% for NSW.

In 2006, it was estimated that there were 480,675 people living in the North Coast Area, with approximately 19% aged over 65 and 17,940 Aboriginal people, comprising 3.7% of the total and around 12% of the total Aboriginal population in NSW. The Area has a high population growth rate and an ageing population. The Area is characterised by a high proportion of the population living

near the coast in major centres, towns and villages and smaller pockets of population in towns in the hinterland.

All these Areas have large numbers of small district, community acute and non acute hospitals, multipurpose services and community health posts and centres. Both Areas also have rural referral and/or base hospitals in regional centres. These provide the bulk of acute and specialist procedural care for the regional catchment as well as specialist mental health and drug and alcohol services that include referral centres, acute units in base hospitals and dispersed community mental health teams and specialist drug and alcohol workers.

There are five Divisions of General Practice in GWAHS, three in GSAHS and four in NCAHS. There are significant shortfalls in the number of general practitioners available in rural and remote communities as shown in Attachment 3. There are also significant and growing shortfalls in procedural GPs providing obstetric, anaesthetic and surgical services in district hospitals in these Areas. These Divisions also access Commonwealth MAHS and Regional Health Program funding and many Divisions employ or contract allied health professionals who provide visiting services to GP practices in medium towns and smaller communities. GSAHS also administers the Commonwealth Rural Health Program in south western NSW.

There are five community controlled Aboriginal Medical Services in GSAHS, nine in GWAHS and ten in NCAHS. GWAHS has implemented the Maari Maa and Murdi Paarki structured partnerships with AMSs and the Commonwealth Department of Health and Ageing to provide integrated primary health care services. Additional project-based funding comes from the Department of

There are a limited number of NGOs operating in the rural Areas and these are mainly located in major regional towns. Other human service agencies are also operating across the Areas with significant recruitment and retention issues for high need rural and remote communities, especially in the western part of the state and in smaller communities in the hinterland of the North Coast.

### **Clinical Operations Model**

GSAHS and GWAHS have a geographical Cluster Manager model with six clusters in GWAHS and three in GSAHS that have line management and budget control for integrated hospital and community health services. Cluster Managers, the Director of Mental Health and Drug and Alcohol Services and some specialised Area wide services report to the Director of Clinical Operations in each Area (see Attachment 4).

NCAHS has four networks covering Tweed/Byron, Richmond, Coffs/Clarence and Hastings/Macleay. Network Coordinators and the Area Allied Health Advisor (who also has responsibility for community health) report to the Executive Director of Clinical Operations. Each network has a coordinator responsible for hospital and community health services and a Community Health and Allied Health Manager responsible for the centres and all allied health staff and community services across each Network. This position is a member of the Network Executive Committee and reports directly to the Network Coordinator.

### **Community Health Service Profile**

The community health service profile varies according to population in all Areas but typically includes the range of services described below.

Major regional towns such as Wagga Wagga, Albury, Dubbo, Orange, Bathurst, Goulburn and Queanbeyan and regional networks in Bega Valley and Eurobodalla on the South Coast and the major cities on the North Coast have comprehensive community health services. These typically have multidisciplinary teams that provide a mix of community nursing, palliative care, early childhood and family health teams, counselling, allied health therapies such as physiotherapy, speech pathology, occupational therapy and podiatry, aged care support and dementia, Aboriginal Health, sexual assault and child protection services. Oral health services are also collocated with

community health centres in many towns. Some of these community based services are managed under contracts with the non government sector. In most locations allied health teams and specialist workers provide outreach services for a regional catchment and in many towns allied health staff work across hospital and community settings.

In the medium and small rural communities community health is generally staffed by a core of generalists supplemented by specialist workers and/or visiting services provided by regional centres or in GWAHS by fly-in services. Primary health care nurses staff community health posts in small towns and communities. The services and typical staffing include:

- Community nurses with a mixed caseload including child and family health, aged care, maintenance and care of people with complex illness.
- Allied health professionals in a range of disciplines (primarily physiotherapy, occupational therapy, dietetics, speech pathology and psychology or social work dependent on workload and capacity to recruit) who may work across inpatient, outpatient and community health settings
- Visiting or fixed dental services
- Some sites may have specialist workers in mental health, drug and alcohol or PANOC
- Some sites will have an Aboriginal Health Worker or Health Education Officer

### **Characteristics of Area Primary Advisory Model in GWAHS**

GWAHS has an Area Manager Primary and Community Health. This is a tier 3 position that reports to the Director of Population Health, Planning and Performance. The Area Manager is responsible for portfolio teams who provide policy and planning advice, strategic leadership and program development support for primary and community health services across the Area. They include:

- **Health Promotion** which manages health promotion staff across GWAHS
- **Primary and Community Health Development** which includes service development initiatives and programs in chronic care, specialist nursing, regional health, falls prevention and HealthOne initiatives
- **Primary and Community Health Partnerships** which includes women's health, domestic violence, HACC and veterans affairs, carer initiatives and HealthOne initiatives
- **Maternal, Child and Family Health** which includes Families NSW, Aboriginal maternal and infant health, paediatric CNCs, youth health, Aboriginal priority programs including SWISH and otitis media, child and family health and clinical midwifery policy and programs.

This directorate monitors State wide policy and works with clinical streams and community health staff and managers across the Area to develop models and redesign services that are appropriate and targeted to the needs of the GWAHS communities. This team coordinates the partnership activities with other government departments, GP divisions and other stakeholders across the Area and is developing the 'HealthOne' projects in GWAHS. The directorate has also undertaken a range of system support initiatives including development of the FERRET community health information system to improve the quality of community health information and program reporting.

### **Characteristics of Area Primary Advisory Model in GSAHS**

GSAHS is currently finalising an operational restructure which has established three clusters with general managers who oversight integrated health services responsible for hospital and community health services.

A range of Area portfolio managers in Population Health, Planning and Performance; Workforce Development and Nursing; and Midwifery Services contribute to policy and practice development and innovation for Community Health Services.

### **Characteristics of Area Allied and Community Health Advisory Model in NCAHS**

NCAHS is also operating on an interim structure and is finalising an operational restructure that has four networks with Network Coordinators who support local managers responsible for hospital and community health services.

NCAHS has developed Area-wide clinical streams for mental health, oral health, drug and alcohol, cancer and palliative care, renal dialysis, emergency services and intensive care services. These streams are managed through a Director also reporting to Clinical Operations.

Population Health, Planning and Performance, Aboriginal Health, Health Promotion and Public Health contribute to policy and practice development and innovation for Community Health Services.

## **8.2 Summary of issues and tensions**

All Areas provide the majority of the 20 community health streams listed in Figure 4 (page 20). The bulk of these services are managed by Primary and Community Health Services with Population Health providing strategic leadership or managing Area-wide health promotion and priority population health programs for Aboriginal Health with some joint service delivery on the ground.

Despite the range of community health services being offered many informants in the field feel that community health had become 'invisible' in their Area and that the focus on promotion, prevention and early intervention is being overwhelmed by hospital demand.

There are mixed views on the best governance and structural options for the future but several themes are consistent:

- Meeting targets for acute hospital care is seen as the ultimate priority for all senior managers in NSW Health especially in the metropolitan and regional areas that are dealing with escalating hospital demand. Most informants believe that primary and community health services need to be at the table and to 'have and be seen to have' a clear role in supporting hospital demand management and avoidance to be relevant in this environment and to provide continuity of care for their existing clients.
- Many informants feel that, without clearly defined primary and community health structures and effective leadership, the 'episodic illness' model will continue to overwhelm prevention and early intervention services for children, families and young people and will continue to reduce interagency partnership programs targeting at risk or vulnerable groups.
- Many community health staff in metropolitan areas feel that acute hospital managers and clinicians have limited understanding of the role and operation of community health services and the service issues or models of care that have been developed to respond to the full range of population health benefit groups. This is especially the case in relation to community health activity targeted to clients who do not encounter the acute care system.
- Numerous examples were provided to the Review of hospital-based managers wanting to redeploy community nurses and community midwives to backfill hospital vacancies, with little concern for the impact on community workloads and models of care. These examples were perceived as essentially cost shifting from hospitals to other areas of the NSW government's human services and to Commonwealth-funded services.
- Models in urban, regional and rural environments are different by necessity. Most senior executives and local managers in rural and regional areas support an integrated model as the

only pragmatic approach for workforce reasons. This is especially the case in smaller health services where a primary health care approach is core business.

- There is a pervasive sense of weariness and fatigue, with restructuring in many Areas being unresolved. There is also widespread frustration that competing models of care and administrative systems have still not been reconciled and that organisational structures that have been evolving since the last restructure in 2005 have not been finalised.

A key issue for the Review is whether a 'one size fits all' governance model can or should be implemented in NSW, given the size of the current Areas, their different health service architecture and diversity of population needs.

The same issues and the same types of solutions were found in national consultations with frontline health workers undertaken in work commissioned by the NHHRC.

*'The idea of a single national healthcare system was suggested by many health workers to address these issues. When conceptualising this idea, many participants felt that while funding should be the responsibility of a single body, health planning and delivery should still occur on a regional or local level, because a local focus, rather than a 'one-size-fits-all' approach, is necessary to ensure health programs are customised to the unique needs and opportunities of specific areas...'*

*Many health workers also saw a single national healthcare system as providing the opportunity to change the underlying framework of the healthcare system from one focussed on acute care to a focus on preventative healthcare, early intervention, and community and home-based care delivery. This includes the opportunity for Government to take a holistic focus – 'whole-of-community' and 'whole-of-life' (beginning with maternal and infant health) and implementing a 'whole-of-government' response'. (Elton Consulting 2008, p.2)*

The majority of community health services in NSW are now managed at a local level as part of an integrated health service system with shared operational management and funding arrangements with hospital services. However, the seniority and responsibilities of community health managers vary widely. Two of the eight Areas have dedicated primary and community health functional streams with senior managers with budget and operational responsibility and two Areas have a group of population focussed or specialist services managed as Area programs. Others have more mixed models.

The current policy settings in NSW and nationally (and internationally) suggest the need for a vibrant community health service at the heart of the health system. There seems to be consensus on the desirability of that direction. But there are few coherent strategies in place on how best to practically achieve a community health and primary care-driven system.

A single organisation and governance model is unlikely to work across NSW. However the policy environment suggests the need for high profile primary and community health leadership at strategic levels within the system with the authority and levers necessary to drive change and improvements in health services and to build effective primary health care partnerships.

## 9 System and capacity issues

### 9.1 Community health centres

There has been little capital investment in community health for at least the last decade and much of the existing capital stock has been poorly maintained. Further, a number of services are provided out of rented premises that were not designed for this purpose. The Review was given clear examples of this situation throughout the consultations.

Due to the cost of bringing existing capital stock up to standard, many community health services are now being retracted onto hospital sites with the properties sold on the basis that they are 'surplus to requirements'. This reflects the reality of a higher value being given to acute care – while capital funding for hospitals is far from easy to obtain, the experience is that it is even more difficult to obtain capital funding for community health. This is despite the fact that the capital costs of community health centres are significantly cheaper.

On the one hand, some respondents to the Review have argued that the collocation of community health on hospital sites provides the opportunity for improved integration of community and hospital services.

On the other, some respondents have argued that, to be effective, community health services need to be located in the community in close proximity with general practitioners and other community care providers and located near shopping and transport hubs.

These differing views are consistent with Leutz's third law – 'Your integration is my fragmentation' (Leutz 1999, p.91).

The perception of those who believe that community health services should be in the community is that many so-called 'community health precincts' within hospitals are excessively clinical and unwelcoming environments, with expensive and hard to find parking and often not located close to transport hubs. There is a perception that this changes the way in which services are provided as reflected in the field consultations and the submissions to the Review:

*'These teams then tend to revert to becoming sedentary traditional outpatient departments again'*

A further issue, illustrated in community mental health, is that there is evidence that joint planning, community location and service mobility results in better outcomes than hospital-based ambulatory services. This evidence is summarised in the associated evidence report (*Community health: the evidence base* - Report No.1). The main issue is how to make these models more sustainable and with wider application. There are numerous examples of pilot studies in selected areas supported by memoranda of understanding and so on in collaboration with Housing NSW, Justice Health, Corrective Services and DADHC.

*'The purpose of the Accord is to improve planning, coordination and delivery of services to assist social housing tenants sustain their tenancies, as well as to facilitate community building and to reduce social disadvantage in larger social housing areas. The Accord can act as the main mechanism through which clinical and social support services will be coordinated and delivered to social housing tenants.'* (Submission to the Review from Housing NSW, p.3).

Several submissions to the Review argued for the need to decentralise community health into smaller geographic sectors, each responsible for a designated population. As one submission argued, effective integration *'will require the decentralisation of community-based services out of hospitals into locally-based polyclinics (with) ... services for a population of 80,000 to 100,000 people'* (Submission to the Review from Dr John Ward, Clinical Leader in Aged Care, Hunter New

England Health, Conjoint Associate Professor, Faculty of Medicine and Health Sciences, University of New England.)

These issues are intrinsically linked to bigger issues, including the role of community health, partnerships and interfaces and hospital demand management.

## 9.2 Workforce issues

The need for NSW Health system to proactively address key workforce issues for the primary and community health sector was raised repeatedly in field consultations. Many of the issues about workforce supply, recruitment and training that are common across the health workforce were raised and are not repeated here. Some of the key themes and specific issues for community health are summarised below.

The community health workforce across NSW, especially the community nursing workforce, is ageing and there are persistent shortfalls in allied health, mental health and other specialist disciplines in outer urban, rural and remote areas that affect service capacity and access. Most Areas and NSW Health do not have accurate staff profiles for the community health workforce or a clear framework to support workforce planning and review of the skills and competencies required in community settings as distinct to hospital settings. This is seen as a major deficit and an impediment to well grounded policy development.

The need to improve dynamic efficiency and achieve more flexible workforce strategies were recurring themes in the Review and they were echoed in the parallel national consultations carried out for the NHHRC:

*'Health workers currently work in silos. Improved service integration could be achieved through implementing new and/or redefined health worker roles... In particular, the training and use of more generalist practitioners with an increased scope of practice would enable more strategic use of skills within the workforce. This reorientation would involve shifting the current focus on training away from specialisation towards the clinical area, and the training of multi-skilled workers who can provide general care. Possible approaches to achieving this outcome included:*

- *Increasing the numbers and making better use of healthcare technicians, service aides, and community-based carers.*
- *Increasing the scope of practice – for example, allowing nurse practitioners and paramedic practitioners to perform a greater range of roles.'* (Elton Consulting 2008, p.9)

Workforce models need to take account of the impact of changing Commonwealth funding on the role and focus of the community health and allied health workforce. During field visits we were told that Commonwealth funding for extended primary care items for chronic and complex disease and programs such as More Allied Health Services (MAHS) is contributing to a drift in allied health professionals to private practice and group practice in rural and some urban areas. In many cases this is depleting the community health and mental health workforce significantly.

In some areas, this has resulted in a net reduction of staff in the public sector without a reduction in patient demand. Gap payments charged by private practitioners limit access to low income individuals or the number of reimbursed visits is insufficient and so patients are transferred back to mental health or community teams for continuing care.

The expansion of the private sector workforce has implications for community health and mental health that are still emerging. But issues such as 'residualisation' (all the hard cases in the public sector), the need to contract in some services and arrangements for rights of private practice to retain or recruit staff were all raised as issues that need to be considered as part of a strategic workforce review.

The need for agreement on a core of evidence based allied health interventions and programs that are required in community health to support early intervention, chronic disease management and community rehabilitation programs was also raised as a priority for workforce and service planning. This would need to include consideration of how new workforce groups such as allied health assistants would be used in the field.

*'There are a number of factors affecting allied health workforce within NSW Health. These include high staff turnover within the public sector, a projected need for more clinical health workers in the future, limited career opportunities and, with a relatively high proportion of females across allied health, the need for more flexible work arrangements.'*

*Incentives to retain allied health staff will serve to strengthen recruitment and retention of allied health staff. This is particularly the case in some areas of community based service provision where there are competing clinical areas of interest from the acute and/or private sectors. Opportunities include in-house clinical education, accessible conference leave, partnerships and links with universities and other agencies as well as support for research.'*  
(Submission to the Review from the NSW Area Directors of Allied Health group)

Nursing practice in community settings has been changing for a decade or more. This is due to higher acuity patients being managed by community nurses, the establishment of hospital in the home and post acute care programs and the shift in early child health models toward assessment and sustained support for high risk and vulnerable families. The introduction of practice nurses with a supervised procedural role in some general practices has also raised issues of role delineation and boundaries that need to be resolved locally and nationally. There was not a clear vision of the future role of community nurses in NSW Health or in most Areas.

Many informants believe that community nurses need to fulfil a role similar to District Nurses in the UK National Health Service. These highly skilled primary health care practitioners provide care in partnership with local GPs for families and patients with complex needs and navigate patients to the allied health, hospital and support services that they need. Others spoke of the need for highly skilled rural generalists or primary health care nurses who practice in remote areas without local backup.

Many informants believe that there is a need to reassess and clearly articulate the practice approach, skills and competencies required in the generalist and specialised community nursing workforce using a framework similar to the 'Working with Essentials of Care' initiative being driven by the NSW Health Department Nursing and Midwifery Office. This would then lead to workforce planning including meaningful workload measures for a variety of community health roles and service settings.

The increasing importance of increasing the number of Aboriginal Health Workers working in health promotion and in clinical roles was raised in many field visits. Current workforce development programs need to be strengthened and many Areas also identified the importance of provide training and support for indigenous people in administration and management roles.

The need for a skilled and valued primary health care workforce and an appropriate community health workforce training and recruitment strategy is a key issue and will need to be considered in the context of the strategic issues that this Review is addressing.

### **9.3 Quality and safety systems**

An important finding from our stakeholder consultations is concern in some quarters that there are deficiencies in the quality and safety systems for community care. Health services in NSW have undergone significant restructuring over the last four years, in some cases restructuring within restructuring. This has resulted in a diversity of organisational models for community health service delivery (described elsewhere in this report).

It would be expected that these changes would result in significant disruption to existing systems and processes (such as quality and safety) which would take some time to realign with the new

organisational structures. Existing models of care may not fit well with the new structures and improving that fit may require major structural and cultural change. Increasing specialisation can result in not only fragmentation of services but also fragmentation of internal systems for clinical governance, such as the development of separate data collection and evaluation systems (see Section 12.7).

Into this mix of uncertainty and change has come a whole series of centrally-driven policy initiatives intended to have a major impact on quality and safety. The following mandatory policy directives (which all cover community health services) have been issued since 2005:

- Patient Safety and Clinical Quality Program (2005)
- Patient Safety and Clinical Quality Program Implementation Plan (2005)
- A Framework for Managing the Quality of Health Services in NSW (originally published in 1999 and reissued as a mandatory policy in 2005) which refers, for example, to 'formal mechanisms in place for assessing the competence of staff who work in isolation from other health workers', a requirement that is very applicable to many community health workers.
- Medication Handling in Community-Based Health Services/Residential Facilities in NSW – Guidelines (2005)
- Reportable Incident Definition under section 20L of the Health Administration Act (2005)
- Complaint or Concern about a Clinician - Principles for Action (2006)
- Complaint Management Policy (2006)
- Open Disclosure (2007)
- Incident Management (2007)

In addition, clinical governance units have been established in each area health service.

The Patient Safety and Clinical Quality Program includes seven standards that area health services are required to comply with:

- Standard 1: Health services have systems in place to monitor and review patient safety.
- Standard 2: Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.
- Standard 3: An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.
- Standard 4: Complaints management systems are in place and complaint information is used to improve patient care.
- Standard 5: Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.
- Standard 6: Performance review processes have been established to assist clinicians maintain best practice and improve patient care.
- Standard 7: Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented

Implementation of all these policy changes would be challenging in a relatively well-resourced, stable, environment. Given the range of issues regarding community health documented throughout this report it would not be surprising, as some stakeholders have suggested, if quality and safety systems were operating sub-optimally. We will return to the issue of quality and safety in our final report.

These reported systems problems do not necessarily imply that community health services are deficient in quality and safety systems. Community health services are part of the accreditation, usually through ACHS, which focuses on clinical and corporate quality and safety. Community health services contribute to this process by providing evidence of attainment of standards and criteria, and conduct a wide range of quality improvement initiatives.

A common theme from a range of stakeholders was about the inconsistency of community health structures, resources and priorities across Areas and the way that innovative and targeted service models can lack impact as a result.

*'Currently there is not a consistent approach within community health to falls prevention. Falls prevention implementation should be identified in Aged and Extended Care Service streams, Chronic and Complex program streams and be core business within effective service provision of community nursing, community rehabilitation, health promotion, and community based hospital demand management service streams. The work being undertaken in clinical redesign aged care and chronic care should include mechanisms in place to identify, manage and refer an older person at risk of a fall.'* (Submission to the Review from the NSW Falls Prevention Program.)

The deficiencies are not in a lack of innovation and models to create improvements in efficiency, but in the sustainability of those models and the often perverse incentives in the system that continue to address traditional approaches to problems, and reduce dynamic efficiency by decisions such as rewarding services with long waiting times.

*'(Our) research project was an example of initiative by workers to put effort into documenting innovations in clinical practices to cut waiting times and make our service more accessible to more people. It was responded to by management with an Area Award but was coupled with being told the service would consequently be placed further down the list for enhancements. This obviously made the effort of making changes and documenting them counter productive to our service. The principle of rewarding services for waiting lists does not seem to match the health policy documents aimed at working with best practice guidelines, accessibility, and primary health care.'* (Submission to the Review from Trish Kenny, formerly Clinical Psychologist, Nowra Community Health Psycho-Social Team, currently Clinical Psychologist, Shoalhaven Mental Health Service.)

There are no shortages of innovative practices and the following lists from the 2007 Baxter Awards highlight the range of programs being undertaken across the state.

Entries in the Primary Health and Continuing Care in the Community category:

- Juvenile Justice Centre Release Treatment Scheme - This project demonstrates that supported follow-up for young people leaving custody in NSW leads to improvements in access to health care, increased health care engagement with family/carers and improved treatment compliance.
- Promoting Health and Nutrition with the Bowraville Preschool - This project aimed to: improve the health of children and their families through early detection, intervention, education and support; and to take services to families who do not access the traditional health services.
- Vulnerable Families Care Coordinator - Development and coordination of a collaborative and integrated care model that provides appropriate services and support for pregnant women following identification of psychosocial risk factors during pregnancy.
- 90% Universal Health Home Visiting "How are we doing it!" - The Child and Family Health Service made significant changes to their service to achieve a 90% UHHV rate.
- Can't Hear, Hard to Learn. - This partnership program informs and educates Aboriginal communities about Otitis Media, screens children for the condition, makes referrals where necessary and supports with treatment, while working with mainstream health professionals.

- Court Mandated Outpatient Treatment (MOT) Options - Results of this project show that the use of Mandated Outpatient Treatment (MOT) has improved outcomes and reduced recidivism for people facing the criminal justice system.
- Developing a high risk foot service in a rural setting - Working within a community health setting, the rural podiatrist has established a telehealth service to facilitate a team approach and provide early diagnosis and treatment to those at risk of amputation from high risk foot complications.
- Frozen Meal Service - Nutritional Care from Hospital to Home - This proactive and cost-effective initiative represented a rung in the “continuum of care” ladder, allowing patients to continue to have nutritious, safe, tasty and economical meals at home after discharge.
- Happy Feet - The establishment of a foot clinic to improve pain and discomfort, mobility and self-care for community members.
- HARK - Health Assessment for Refugee Kids - The HARK service provides comprehensive health assessment, treatment and support for newly resettled refugee children in NSW.
- Improving access to primary healthcare among injecting drug users in Redfern - This project illustrates how a community-based needle and syringe program (NSP) improved access to primary healthcare and addressed the unmet health needs of injecting drug users.
- Koori Kids Koori Smiles Oral Health Program - Designed to provide Aboriginal children and adolescents between the ages of 0 – 17 years with culturally appropriate oral health information and clinical dentistry in a culturally appropriate environment.
- KYHT – Keeping Your Head Together - A project that aims to reduce the mental health problems associated with substance use by young people.
- Management of patients with cellulitis using intravenous antibiotic therapy - The project aimed to implement this model of care locally for patients presenting to John Hunter and Belmont Hospital Emergency Departments (ED).
- Outcomes of a class for clients with chronic low back pain - A treatment program to improve and maintain functional outcomes following lumbar spine surgery or chronic LBP.
- Physio’s Think Kids - A professional development day for physiotherapists working with children aimed to provide the most current information and practical strategies, as well as encouraging networking for paediatric physiotherapists.
- Single Access Service to the Community Health Network - The Referral and Information Centre (RIC) has been developed to enhance existing services by improving and integrating access to community health services.
- Warfarin management in Acute Stroke Patients Project - This project aims to improve the Warfarin management, education, safety and compliance in acute stroke patients utilising the “Safer Systems Saving Lives” (SSSL) concept.

Other entries to the 2007 Baxter Awards that have a community health component included:

- In Partnership - Promoting Health through Strategic Partnership in Local Government in SWAHS - This model provides a blueprint for other health services for developing and maintaining sustainable partnerships with local government.
- Improving cross-border cancer care coordination - The Border Cancer Collaboration (BCC) has been successful in establishing a multi-disciplinary approach to cancer treatment and support for patients, families and carers for the Albury/Wodonga region.
- Fairfield Falls Intervention Program - This project developed a multi-disciplinary Falls Intervention/Prevention service within the Fairfield Ambulatory Care Service.

- Speech Pathology in Schools Project - The Schools Project involves teams of speech pathology students working with selected schools to support children's communication and language skills in the school context.
- Partnerships and Provision of Parenting Programs - Through early intervention and appropriate response this program aims at reducing behavioural and emotional problems of children.
- Rural Youth Destination Outreach Network (RYDON) - A program to provide affordable transport for 12 up to 24 year olds in areas that are transport disadvantaged during school, public holidays and weekends.
- Karitane Volunteer Program (KVP) - This program offers the unique skills of specially educated volunteers, with their own parenting experience, to assist paid staff to provide home visits, telephone and group support to families in the antenatal period and families with children up to three years of age.
- Youth and Road Trauma Forum - The Forum's primary objective is to reduce the fatality and injury rates of young people and to ensure that the community is aware of injury prevention, trauma care services and related resources available.
- Eye surgery in Moree - A collaborative process - The sharing of information, knowledge, staff and equipment between the three organisations allowed state of the art equipment to be based in Moree to provide a high quality ophthalmology service to the community of Moree and surrounding districts.
- Developing knowledge and skills for diabetes prevention - The implementation of a service which provides a pathway for rural health professionals to participate in diabetes education, and share that knowledge with the broader community.
- Toomelah Boggabilla Strategy - The development of an effective, long-lasting partnership between the Aboriginal communities of Toomelah and Boggabilla and government agencies in NSW and Queensland to build community capacity and improve the health and wellbeing of these communities.
- Building Our Rural Mental Health Workforce - The employment of ENs to carry out a specific role within the mental health team enabled a more flexible approach to existing workloads.
- Improved functional outcomes in heart failure patients - Describes the introduction of an effective exercise rehabilitation program that was appropriate for heart failure patients in the Sutherland Shire LGA.
- Using knowledge to safeguard our nations - This project aimed to determine the prevalence of risk factors for CKD within an Indigenous population as part of developing a holistic strategy to prevent end stage kidney disease.
- Adult Health Check Events - The AHC provides an opportunity for local health services to screen clients for chronic disease in order that the disease can be detected early and managed successfully.
- Go Active Program - This program was established to provide an enhanced community based service addressing the growing demand on health resources in the areas of aged and chronic care.
- Aboriginal Youth Sexual Health and Didgeridoo Project - This unique Aboriginal youth sexual health didgeridoo and craft project developed because the Aboriginal community of Goulburn identified a need to educate and promote important health issues.
- Life...Live it: Save it! - This project aims to increase community awareness regarding early recognition of signs and symptoms of potential life-threatening medical conditions, and seeking medical advice immediately.
- Caring for Moulamein and District Families - Promoting health and well being in the community through assessment and targeted programs.

- LOVE BITES Program - A successful community partnership - A comprehensive Domestic Violence and Sexual Assault Prevention Program for High School Students.
- Safe Club - 'SafeClub' program was developed to help community sports clubs implement their own user friendly risk management framework and has resulted in a significant increase in safety activities.

Despite the current array of projects and activities, community health lacks a coherent approach to supporting and sharing information and ideas on quality and safety.

This is understandable considering the complexity of the models of care, service types and organisational arrangements. The example of a more coherent approach to quality and safety that should be extended into primary care is the work in nursing and midwifery in NSW Health mentioned in the previous section (*Working with Essentials of Care*) which has produced a web-based resource manual to assist staff across a range of quality and safety issues. These issues and associated recommendations will be addressed in our final report.

## **9.4 Community health information**

Throughout the review we have received feedback on the inadequacy of current community health information and current community health information systems. Several themes have been consistent:

- Community health practitioners either have no access to electronic information systems or, if they do, are mostly working with systems that are too slow and too burdensome to justify their efforts.
- Mobile staff such as community nurses and others need access to mobile information technology so that they can introduce efficient work practices that they recognise are long overdue
- With few exceptions, much of the information that is currently captured is not clinically useful. There is a need to capture both a core set of generic information as well as clinical assessment and other data that are specific to each discipline and stream of care.
- There are many examples (see previous section) of community health staff undertaking their own service evaluations and documenting what they do in reports. While these may be disseminated locally, there is no central repository of information and no central community health knowledge management strategy.
- In the absence of any other routinely collected and reported information, the only data that are centrally reported are counts of occasions of service.

On the one hand, many executives and managers at both the departmental and area level are critical of community health because it cannot demonstrate what it does. On the other, neither the data systems nor the information technology are in place that would allow community health to do otherwise. A major investment is required, an issue that will be discussed in our final report.

### **The need for performance indicators for community health**

There is widespread recognition of the need for meaningful performance indicators for community health that are the by-product of routinely collected information. However, the implementation of such indicators presupposes that both the information technology and the data systems are in place, neither of which is the case at present (see above). Nevertheless, some important developmental work has been done that will be discussed in our final report.

## 9.5 Telehealth

Telehealth is recognised as a major tool for 21<sup>st</sup> century health care with potential to support self care and remote monitoring for people with chronic conditions and to link clinicians in metropolitan and rural settings and internationally to improve access to health care and expert advice.

NSW Health has established telehealth infrastructure across NSW and videoconferencing is now routine practice in most Area Health Services and in NSW Health to reduce travel time and to provide remote education and training.

Tele-radiology is also well established across NSW, there are remote ophthalmology and diabetes foot care services in operation and there have been trials in emergency department telemedicine and critical care. Tele-psychiatry models are also widely used in specialist mental health services in community settings in NSW. These have improved access to psychiatry services in rural and remote areas and reduced the need for patients to transfer from small hospitals and local community mental health teams to major hospitals for assessment and case management.

Despite the potential we were advised during field consultations that there is limited uptake in allied health or other primary health clinical services despite working models in other jurisdictions and internationally. Issues identified that inhibit the application of telehealth in community health services include:

- Telephone and broadband charges for telehealth consultations are paid by the users and this is a high cost for most local community health services and sites in rural Areas. We were also advised that this has impacted on the willingness of staff in specialist centres to provide consultancy or clinical services using this medium.
- Formalised networks with specialist providers and regional teams are often not in place and this is needed to develop protocols for use. While some remuneration models are available for medical specialists there is no agreed system for 'paying' for allied health or specialist nursing consultant time across Areas and this is an issue when resources are tight across the system.
- Investment is needed in state of the art local and statewide architecture for home health monitoring that GPs, specialists and community health staff can link in with. The call centre model for coaching is one tool being rolled out across NSW but home based vital signs monitoring systems, medication reminders and other tools that can reduce the need for some home visiting are required to support self management for chronic and complex patients.

While some of the building blocks and basic networks are in place further strategic investment in telehealth care systems and clinical care protocols and home care support technology will be required to take advantage of the potential of these mediums and impact on primary health care practice.

## 9.6 Planning tools and models

While there are well developed planning tools and models for acute hospital services, there is a dearth of equivalent tools for the planning of community health services in NSW. Carla Cranny & Associates et al. (2007) in their work on *Health Hubs and Precincts* for Queensland Health's Planning and Coordination Branch, designed a service planning, classification and decision support tool to assist plan the best service mix for their proposed sites and other locations.

The lack of support in this area in NSW reflects in part the lack of a standard classification of community health services and interventions and the lack of routinely collected data that can be used to inform future planning. While these problems will not be resolved in the short-term, there is no reason why work to develop a much-needed 'Guide to Community Health Role Delineation' could not begin in 2009.

## **9.7 Funding models**

While NSW Health has undertaken significant work to develop better funding models for hospitals, no such work has been undertaken for community health. The current NSW Health episode funding guidelines flag the intention to extent episode funding to community health. However, this requires the development of a suitable casemix classification for community health and the consistent collection of the information required to populate the classification. Some preliminary casemix work was undertaken nearly a decade ago that demonstrated that this was feasible. But it was not pursued. Some ten years on, it is necessary to begin this work again.

While it is early days, developments at a national level may provide some opportunities to develop some more flexible pooled funding models, particularly for rural and remote areas. As the expert papers commissioned by the National Health and Hospital Reform Commission demonstrate (see Section 6.1), there is considerable support among experts for the use of mechanisms such as funds pooling to drive workforce reform and to create the required incentives for improving equity of access to primary care across the country.

## **9.8 Teaching and research**

As health care moves increasingly to the community, it is becoming more important to provide opportunities for the teaching and training of health professionals to also occur in a community setting. It is also important to provide opportunities for ongoing discipline specific and multidisciplinary professional development. While some teaching and training is occurring in community health environments, the level needs to be expanded to meet changing workforce needs. As with teaching in hospitals and general practice, appropriate community health infrastructure (human and capital) is an essential prerequisite of a quality learning experience for the student.

In relation to research and development (R&D), there are many examples (some of which are included in Attachment 2) of community health staff undertaking their own service evaluations and documenting what they do in reports. However, from the consultations within the Department, with academic units and in the Areas, there is no systematic investment in R&D and not a strong R&D culture. Further, there is no central repository of best practice information on community health and no central community health knowledge management strategy.

There are models in the literature on population-based research that include researchers as advocates for the population, with research combined with better meeting immediate care needs and directly influencing popular expectations (see [Community health: the evidence base](#)). In particular these models in Wales in the period of the 1950s through to the 1990s, reinforced the value of participatory models in improving response rates in epidemiological research (Tudor-Hart and Smith, 1997).

## **9.9 Summary of issues and tensions**

This section of the report has discussed system and capacity issues, many of which apply equally to general practice. These are the enablers for community health services to fulfil their charter. It is fair to say that compared to the investment in these issues as they apply to hospitals, there has been minimal investment in these essential community health enablers. Many community health centres are run down and services are being increasingly relocated back to hospital campuses, with implications for reduced access for those clients most in need of publicly funded community health services.

There are significant workforce issues and all the predictions are that these will become more problematic. In spite of there being many examples of good practice, sustainability is a problem and very few quality and safety systems are systematically in place and there is a dearth of good quality community health information. The use of telehealth models is patchy and is being hampered by cost issues. Planning tools, funding models and quality teaching and research

opportunities are scarce. Regardless of the future direction that is adopted after consideration of our final report, there will need to be a significant investment in addressing these issues.

## 10 Partnerships and linkages

Throughout our consultations, we have heard about the need for community health to have effective linkages and partnerships both in the care of individual patients/clients and at the service/regional level. A consistent theme around partnerships was the need to establish and maintain structures that can link effectively to primary medical care, with the aim of not only increasing integration across primary care, but also improving the technical efficiency of community health services. The HealthOne initiative was cited as an example of how NSW is moving in the right direction by a locally planned approach, and the parallels with the Commonwealth's rollout of GP Super Clinics were drawn.

The strong views expressed on partnership and linkage issues included those around efficiency gains by more effective consumer and carer participation.

*'There is a recognition that these previously taken-for-granted aspects of care giving contribute significantly to the healing process. Traditionally this type of care was provided informally. As the value of such care has come to be recognised partnerships have grown up. Managing such partnerships can be quite difficult and tends to be made worse when a command and control approach is taken rather than a participatory model'* (Submission to the Review from Peter Whitecross, Manager Community & Consumer Participation, Northern Sydney Central Coast.)

This view is confirmed in the literature on the effectiveness of community health interventions (see [Community health: the evidence base](#)), and in particular as noted above in relation to the value of participatory models in improving response rates in epidemiological research (Tudor-Hart and Smith, 1997).

Our on line survey sought views on partnership issues and the results are presented in Table 2. The 71 respondents to this question could select as many responses as they wished in identifying what they see as priority relationships for community health. In total, 85% selected relationships with GPs as a priority, followed by HACC services at 84%. Within Area Health Services, relationships with hospitals were seen by more people as important than relationships with public health units (75% versus 45%).

**Table 2** *Priority relationships and interfaces for NSW Health community health services*

	Response	
	Percentage	Number
GP	84.5%	60
Home and community care services	83.1%	59
Hospital	77.5%	55
Health NGOs	69.0%	49
Local government services	52.1%	37
Other State government services	50.7%	36
Other Commonwealth funded services	47.9%	34
Public health units	46.5%	33
Residential aged care	43.7%	31

The concept of inter-agency work and clinical partnerships, self help and participation, has always informed the work of community health services.

*'The participatory ethos of community health contributes more to its distinct character and effectiveness than is often acknowledged. People joining in; joining each other, and making*

*a contribution (other than a transactional monetary one) to their health runs counter to a concept of health as a commodity.*' (Submission to the Review from Peter Whitecross, Manager Community & Consumer Participation, Northern Sydney Central Coast.)

*'The community health system's pivotal, enabling role ... is central to the health and well-being of many social housing tenants.'* (Submission to the Review from Housing NSW, p.2.)

We were advised of many contemporary examples of effective partnerships on the ground during our consultations. These ranged from:

- Structured collaborations designed to improve health and wellbeing and health outcomes for Aboriginal people with formal governance, funding and support arrangements such as the Maari Ma and Murdi Paarki initiatives in GWAHS that involve Aboriginal communities, the Commonwealth, NSW Health and other agencies.
- Delivery of the Aboriginal Mothers and Infant Health Strategy in partnership with Aboriginal Medical Services and communities across NSW.
- The Greater Metropolitan Clinical Taskforce (GMCT) has over 30 consumer and community participants as active partners with clinicians across the GMCT Specialty Service Networks (e.g. on kidney donation, bone marrow transplants and gynaecological oncology), to ensure that high quality care is delivered, access is improved and specialty services are well coordinated. In particular, their involvement helps to ensure that clinical discussions remain patient focused. The GMCT has published Guidelines on Consumer and Community Participation.
- Implementation of joint early intervention and support programs for at risk children with NGO partners and family support services under Families NSW.
- HealthOne projects with general practice in rural and metropolitan Areas
- Memoranda of Understanding with GP Divisions and mental health partners such as Housing NSW, DADHC, Corrective Services and Justice Health.

Despite these successes we were advised of a range of issues that make the landscape for successful partnering and partnerships complex and challenging.

The most effective partnerships that were cited in the consultations and submissions have involved staff at the local level working with GPs and other services in sustained ways over time. The increasing acuity and acute focus of the community health workload has meant that valued services cannot be sustained and this affects trust. A number of submissions from other government departments highlighted their concerns that the current pressures on community health squeeze out the opportunities for joint planning and reduce the capacity for support of innovative models of care.

*'For example, attendance at DADHC planning sessions by NSW Health staff is often dependent on the work priorities faced by those staff at the time.'* (Submission to the Review from the Department of Ageing, Disability and Home Care, p.17.)

The size of the Area Health Services and their authority structures has become a problem for local human services agencies and for Divisions of General Practice that focus on the needs of localities or sub regional populations. This is compounded by increased Commonwealth funding for enhanced primary care services, family support and mental health initiatives that target general practice or the non government sector, is submission-based and is poorly coordinated with state or Area Health planning. Rather than simply adding to the quantum of service, there are problems with duplication of effort and competition for the recruitment of staff on the ground.

While the focus on prevention, early detection and action on the social determinants of health is seen as essential, the system as a whole maintains priorities and incentives that make that focus difficult to maintain and sustain over time in practical terms.

*'Despite a number of plans and strategies that display an admirable commitment to 'making prevention everybody's business', 'strengthening primary health and continuing care in the community' and 'making smart choices about the costs and benefits of health services', financial and political imperatives continue to be dominated by the 'crisis' end of the health spectrum.'* (Submission to the review from the Council of Social Service of NSW)

Information systems to support integrated service delivery with GPs and NGOs including common referral and assessment tools and shared medical records are poorly developed or not available in many Areas. Centralised intake and referral systems and other tools making a difference to timely service responses to priority referrals are needed.

*'There is frequent role confusion between agencies which can sometimes be addressed at a local level but which requires a joint high level working party to generate memoranda of understanding and to allocate management responsibilities.'* (Dr Robert Leitner: Comments for the Community Health Review, Developmental Assessment Service, Division of Women's & Children's Health Services, Central Network, South East Sydney Illawarra Area Health Service, p.5.)

Youth health was an area often cited in consultations as an obvious choice for partnership arrangements and where community development approaches are most effective (Kang et al 2005). *'Youth Health Services play a key role in accessing and engaging hard-to-reach, marginalised young people.'* Youth health is also shaped by a set of service types that do not easily fit within an approach that is dominated by vertically integrated clinical streams and often the health contribution is one where investments can lead to savings in other portfolios, not necessarily inside the health sector.

*'Due to the organic development of youth health in NSW there is an inequity in the allocation of resources across the state. While most Area Health Services (AHSs) have very few youth services, some have no specific youth health services that are part of either Community Health or the NGO services and Headspace communities of youth services... Further, there has been no significant injection of funds into youth health services managed by Community Health since they were set up 10-15 years ago.'* (Submission to the Community Health Review from Fiona Robards, Coordinator and Clinical Professor David Bennett, Head, NSW Centre for the Advancement of Adolescent Health, p.2 and p.3)

The opportunities to enhance partnerships are considered in our final report.

## 11 Future role of community health within the NSW health system

Two views on the future role of community health within the NSW health system that have been put to the Review are essentially incompatible. On the one hand is the view that community health should provide the full range of services from prevention to palliation.

On the other is the view that there is a critical need to define a set of core programs that are evidence based with measurable key performance indicators. Implicit in this second view is an assumption that at least some of what community health services currently do is of low priority and can be abandoned in favour of a set of core services that are higher priority or more effective.

The review of the international evidence commissioned as part of the current Review is designed to inform this issue. However, the evidence alone is insufficient to draw a conclusion about core services and disinvestment in the NSW context, if for no other reason than that, as the compendium report (*Community health: the evidence base*) demonstrates, there is actually a reasonable to strong evidence base for services that are typically provided under the auspice of community health. This places Area Chief Executives in a difficult position between their performance indicators and related incentives, the pressures to conform to the State Plan and current health policies, and the available evidence base on the individual and social determinants of health, all of which are needed to inform their hard decisions in hard times.

*‘Just as clinicians are required to justify their decisions with evidence these days if at all possible, so too should health managers. Managerial decisions that can determine the effectiveness of health service delivery should not be based on opinion or tradition. Decisions, even those with seemingly minor implications, should be on nothing less than the best available evidence. The concept of Evidence-Based Management (EBM) - that all decisions are to be based on the best evidence available - is also about facing the hard facts as to which strategies are effective and which are not.’ (Wallace, 2008, ‘On the Importance of Evidence-Based Management’)*

The ability to deliver on models of care that include other sectors of government was highlighted in submissions to the Review that pointed out the future role in support of ‘whole of government’ and ‘whole of community’ initiatives.

*‘Community health services also play an important role in assisting homeless people or people at risk of homelessness in the community ... crucial to the early identification of ... individual factors that can lead to homelessness, such as poor health or mental illness.’* (Submission to the Review from Housing NSW, p.3).

A consistent view was put to the Review that a re-vitalised community health sector could be an important driver for wider changes:

*‘Specifically we support the recommendation to “reframe the NSW Health System” (NCOSS, 2008, p.5) so that acute care, inpatient services, community services and other aspects of the health care system, including allied health and general practitioners are considered jointly in any investigation, strategy, policy and structure of the health system in NSW.’* (Submission to the Review from NSW Consumer Advisory Group – Mental Health Inc.)

In essence, the key issue is that of allocative efficiency – what is the best mix of community health inputs/services that will best meet the health needs of the NSW population? In addition to reviewing the international evidence, we have been seeking views on this issue throughout the Review and two perspectives are shown in Figure 5 and Table 3.

Figure 5 shows the views of the survey respondents on the best investments within each stream of community health. In relation to Aboriginal health, for example, 29% of responses suggested that the best investments were in health promotion, 30% in prevention and early intervention, 7% in investigation, 17% in treatment and 18% in continuing care. It will be seen that, regardless of the stream, there is support for investment in community health across the full spectrum from health promotion through to continuing care.

In fact, while there was less support for investigation as the best investment in community health, there was equal support (within one percent) for health promotion, prevention and early intervention, treatment and continuing care.

*‘Given the evidence for efficacy and cost efficiencies of early intervention, the development of specialist early intervention teams also need to be addressed as a matter of importance. The integration of therapists with the Diagnostic & Assessment Team would minimise the gap between assessment and therapy with more timely provision of services. This would also increase the capacity of the services to meet the complex, diverse and emerging needs of many client families.’* (Dr Robert Leitner: Comments for the Community Health Review, Developmental Assessment Service, Division of Women’s & Children’s Health Services, Central Network, South East Sydney Illawarra Area Health Service, p.5.)

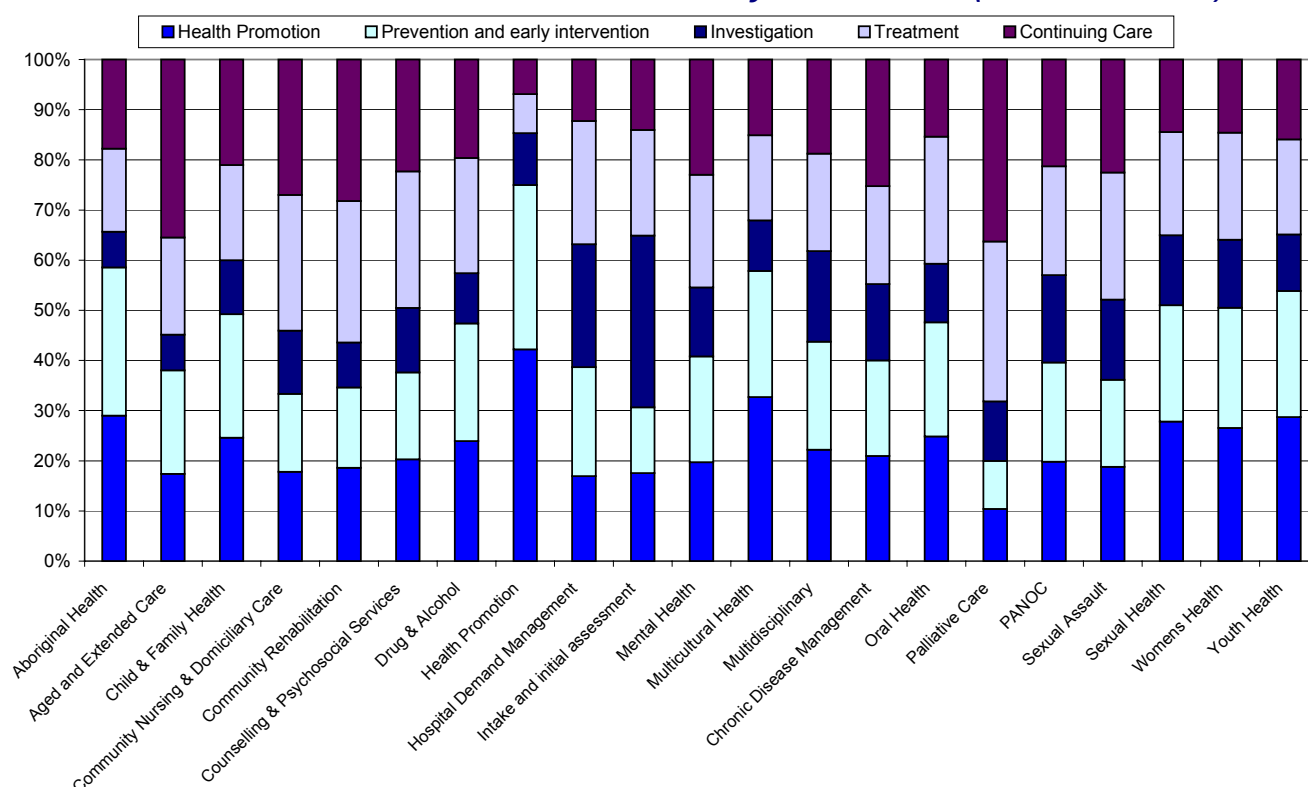
Table 3 reports views from the same survey about service intervention points to where there should be more or less investment in the future. Responses indicating that the current level of investment should be maintained at the same level are excluded. Across all responses, 74% were for more investment and 24% were for maintenance of the current level of investment.

Overall, only 3% of the responses reported in Table 3 favoured a reduction of current investment. While this survey was not administered to a representative sample of key stakeholders, these

results are consistent with the consultations we have undertaken. There is a perception in some quarters that some community health services may have undertaken low priority activity in the past.

But there is a widely held view that this is no longer the case or as one stakeholder in the consultations put it: *'There's no fat left. Community health has been trimmed to the core and everything they do now is a priority.'*

**Figure 5** Views from the on-line survey about the intervention types that provide the best investment within each community health stream (as a % of stream)



**Table 3** Views from the on-line survey about where there should be more or less investment in the future

Stream	Health Promotion		Prevention and early detection		Investigation		Treatment		Continuing Care	
	More	Less	More	Less	More	Less	More	Less	More	Less
Aboriginal Health	67.4%	4.7%	87.5%	0.0%	60.9%	8.7%	67.9%	0.0%	68.8%	3.1%
Aged and Extended Care	69.2%	7.7%	83.3%	4.2%	66.7%	4.8%	76.9%	3.8%	86.2%	3.4%
Child & Family Health	76.9%	2.6%	72.7%	3.0%	58.3%	0.0%	75.0%	0.0%	84.8%	0.0%
Community Nursing & Domiciliary Care	71.9%	3.1%	76.7%	0.0%	59.1%	0.0%	84.0%	0.0%	75.0%	3.6%
Community Rehabilitation	64.0%	4.0%	76.9%	3.8%	54.5%	4.5%	91.7%	0.0%	84.6%	3.8%
Counselling & Psychosocial Services	84.6%	0.0%	88.2%	0.0%	79.2%	0.0%	89.7%	5.1%	94.6%	2.7%
Drug & Alcohol	66.7%	2.8%	66.7%	6.1%	51.9%	7.4%	65.6%	0.0%	66.7%	6.1%
Health Promotion	73.3%	3.3%	88.0%	0.0%	25.0%	12.5%	26.7%	6.7%	47.1%	5.9%
Hospital Demand Management	56.5%	13.0%	69.6%	13.0%	50.0%	9.1%	52.6%	10.5%	52.2%	17.4%
Intake and initial assessment	63.2%	0.0%	70.0%	0.0%	72.7%	4.5%	76.2%	0.0%	66.7%	0.0%
Mental Health	76.3%	0.0%	75.8%	0.0%	58.6%	3.4%	79.4%	5.9%	81.6%	2.6%
Multicultural Health	64.0%	4.0%	68.2%	4.5%	29.4%	5.9%	41.2%	5.9%	47.4%	5.3%

Stream	Health Promotion		Prevention and early detection		Investigation		Treatment		Continuing Care	
	More	Less	More	Less	More	Less	More	Less	More	Less
Multidisciplinary	80.8%	3.8%	88.5%	0.0%	76.0%	0.0%	88.0%	0.0%	80.8%	0.0%
Chronic Disease Management	88.5%	3.8%	83.3%	3.3%	74.1%	3.7%	79.3%	3.4%	75.0%	7.1%
Oral Health	82.8%	0.0%	88.5%	0.0%	64.0%	4.0%	89.3%	0.0%	84.0%	0.0%
Palliative Care	52.4%	4.8%	52.6%	0.0%	36.8%	5.3%	58.3%	8.3%	70.8%	0.0%
Physical Abuse and Neglect of Children	85.3%	0.0%	91.4%	0.0%	86.2%	3.4%	86.1%	0.0%	81.1%	2.7%
Sexual Assault	78.8%	0.0%	83.8%	2.7%	78.6%	0.0%	81.6%	0.0%	81.1%	2.7%
Sexual Health	72.4%	0.0%	75.9%	0.0%	52.2%	0.0%	58.3%	8.3%	57.7%	15.4%
Women's Health	73.5%	0.0%	76.5%	0.0%	66.7%	0.0%	73.3%	0.0%	73.3%	0.0%
Youth Health	88.6%	2.9%	91.4%	0.0%	73.1%	0.0%	75.0%	3.6%	80.0%	6.7%

As we noted in our introduction, this is a strategic and not an operational review. As such, it was not the role of the Review to evaluate existing services or what they do. That said, the fundamental issue for the Review in its final stages, and for NSW Health once the final report is considered, is to make judgements about how to maximise allocative efficiency across the whole of the NSW health system.

The set of judgements to be made by NSW Health about the way forward for community health need to start from the international evidence and an appraisal of the current *State of Play*. These decisions have to take into account the best available evidence and the expert opinion of key stakeholders, including partners inside and outside of government, on how best to organise and deliver effective action on the individual and social determinants of health problems.

## 12 Critical issues that will shape the future

A set of strategic issues emerged early in the life of the Review and these did not change through the consultation process. These issues were the subject of a special meeting of the Review Steering Group in September 2008 and their views are incorporated into the discussion of these issues in this section.

The starting point for these issues is the State Health Plan because it sets clear strategic directions for the future:

1. Make prevention everybody's business
2. Create better experiences for people using health services
3. Strengthen primary health and continuing care in the community
4. Build regional and other partnerships for health
5. Make smart choices about the costs and benefits of health services
6. Build a sustainable health workforce
7. Be ready for new risks and opportunities

However, our Review has found that the current situation is inconsistent with these directions. In particular:

1. Investment in community health has declined relative to overall health spending in NSW
2. Despite declining relative investment, consultation to date suggests that community health is still expected to be all things to all people

3. Significant evidence was collected through the Review of a growing mismatch between NSW community health policy (where the priority is on prevention and early intervention) and NSW practice (where the priority is on short-term hospital demand management).

### **12.1 Strategic vision for the NSW health system**

In the light of this, we sought the views of members of the Review Steering Group on options for the future. The options imply bigger questions about the role of the NSW health system specifically whether, by default, the NSW health system is inevitably on the way to become simply 'an acute hospital system'. Nine of the eleven members of the Steering Group who responded on this issue think that this is where the system is currently heading, with a member of the committee commenting that community health now is the victim of 'benign neglect'. Based on our consultations, this view is also widely held in the field.

*'When community health was placed with acute care, it seemed that the whole system might be able to take a step forward if one part took two steps backwards. This was a very simplistic notion of catch-up or at best did not take account of the decades of time needed for change by the whole system'.* (Submission to the Review from Anne Collings, Director St. Vincent's Community Health Service.)

This issue is obviously bigger than the scope of this Community Health Review. But its resolution is fundamental to the future of community health in NSW.

### **12.2 The role of community health within the NSW health system**

As we noted above, two essentially incompatible views have been put to the Review. On the one hand, community health should provide the full range of services from prevention to palliation. On the other, there is a need to define a set of core programs. Implicit in this second view is an assumption that at least some of what community health services currently do is of low priority and can be abandoned in favour of a set of core services that are more effective.

The review of the international evidence commissioned as part of the current Review is designed to inform this issue. However, the evidence alone is insufficient to draw a conclusion on this issue if for no other reason than that, as the compendium report demonstrates, there is actually a reasonable to strong evidence base for services that are typically provided under the auspice of community health. In the absence of strong evidence, consensual agreement would be required about what services currently provided would *not* form part of the core. The view from the field is very clear on this:

*'...does not see that anything further can be cut out of community health, and in fact has highlighted a number of gaps and recommendations for enhancements to community health.'* (Submission to the Review from the Council of Social Service of NSW)

As discussed above in Section 11, there is no agreement at any level of NSW Health about what services currently provided would *not* form part of the core.

### **12.3 Hospital demand management**

There is clear agreement and evidence to suggest that there will be an increasing need for more effective hospital demand management that is designed to prevent avoidable admissions, to facilitate early hospital discharge and to reduce the rate of hospital readmissions. But that does not mean that this role is best undertaken under the auspice of community health services.

There are mixed views on this issue and the pros and cons were discussed above in Section 7.5. A strategy for resolution of this issue will be included in our final report.

## **12.4 Governance of community health**

As Section 8 and Attachment 4 so clearly illustrate, there are different organisational and governance structures in place in each Area Health Service. A key strategic issue is thus the best governance structure of community health into the future.

Among the Steering Group, the majority view is that there needs to be a standard governance arrangement, with most (but not all) believing that community health should be managed as a single area program by an Area Director of Primary and Community Health. Only a minority of members support flexible arrangements at the Area level.

Those in the field hold a different view, no doubt in part because of history and because of the different arrangements that are already in place. Of the 67 people who responded to our on-line survey on this issue, only 21% thought that there should be one standard model across NSW.

Nearly a third (30%) of respondents to the survey believe that there should be flexibility for different models between Area Health Services, but only one model within an Area while 45% believe that there should be flexible both within and across Areas. While 5% were not sure, a quarter of all respondents provided comments including a range of other governance models. These included dismantling community health altogether, pulling out some services and establishing them as separate streams while leaving other services under a community health umbrella and reorganising the whole service around specific diseases.

## **12.5 Community health as a primary (generalist) or specialist service**

This issue was discussed in Section 7.6. As with the issues of governance and hospital demand management, there is no consensus on this issue at any level of the health system.

This is not surprising as the determination of the right balance between specialist and generalist services depends on the preferred model and development pathway and needs to take account of a number of issues:

- The allocative and dynamic efficiency of the overall health system (see the compendium evidence report for a discussion on this issue)
- Projected workforce shortages
- Career development and promotion opportunities for staff
- How best to deliver services to consumers whose needs cross more than one speciality
- The interface between community health speciality programs and key partners such as general practitioners
- The different needs in urban and rural areas.

Ultimately, the right balance depends on the future role of community health taking into account the range of issues that this report has highlighted.

## **12.6 Linkages, partnerships, regional inter government planning and interagency service delivery**

Section 10 above discussed the key issues relating to linkages and partnerships. The key issues for the Review are in the strategies that promote effective linkages within and beyond health.

In considering this issue, Leutz's Laws of Service Integration are relevant. Based on a comparative study of UK and US service coordination and integration models, Leutz (1999, 2005) developed 6 principles to guide integration of health and community care:

1. *You can integrate some of the services for all the people, and all the services for some of the people, but you can't integrate all of the services for all of the people.*
2. *Integration costs before it pays.*
3. *Your integration is my fragmentation.*
4. *You can't integrate a square peg and a round hole.*
5. *The one who integrates calls the tune.*
6. *All integration is local.*

Each of these principles is relevant to this Review.

## ***12.7 Information and information management***

Section 9.4 above outlined the current state of community information and information management and what is required. While there are many information technology issues, the issues are not limited to IT. In meetings with executives and managers at both the departmental and area level, we heard criticism of community health services because the staff cannot demonstrate what they do. But neither the data systems nor the information technology are in place that would allow community health services to do otherwise. These issues are part of a larger discussion around the efficiency of the NSW health system as a whole (NSW Independent Pricing and Regulatory Tribunal, 2008). Whatever options for a development pathway are chosen, a major investment is required.

While the work currently being undertaken to develop a community health information system under the Primary, Community and Outpatient Care Information Program will help, there is a need to refine the current proposals as outlined in Section 9.4. This will require a strategy to ensure that community health managers and clinicians and the information technology and information management areas of NSW Health work closely together to refine the specifications, implement the systems and change both the culture and work practices.

## ***12.8 Position of community health in NSW in terms of national reform and Commonwealth opportunities***

As discussed in Section 6.1 above, the National Health and Hospitals Reform Commission proposed in its *Beyond the Blame Game* report, that community health should become a Commonwealth responsibility. A key strategic issue for NSW is therefore how it responds on this issue. In the absence of a detailed proposal, it is difficult to know what this suggestion means in practice at this stage.

While our final report will address this issue, the timing of the various national reform agendas is such that the issues will need to be revisited in mid-2009.

## **13 Conclusion**

This *State of Play* report has described community health in NSW in 2008 and a series of strategic issues were outlined above. Our compendium report (*Community health: the evidence base*) synthesises the international and national evidence on community health interventions and services. These two reports inform the final report (*Community health at the crossroads: which way now?*) that sets out a proposed strategic direction for the future of community health in NSW.

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## Attachment 1

### *Proposed health system performance indicators (AIHW 2008)*

#### **Better health**

1. Life expectancy at birth (including the gap between Indigenous and non-Indigenous Australians)
2. Infant and young child mortality (including the gap between Indigenous and non-Indigenous Australians)
3. Incidence and prevalence of important preventable diseases and injury
4. Potentially avoidable deaths

#### **Focus on prevention**

5. Proportion of persons overweight and obese
6. Proportion of persons underweight
7. Proportion of persons who are daily smokers
8. Proportion of adults with high blood pressure
9. Proportion of adults with high blood cholesterol
10. Proportion of adults who are physically inactive
11. Low fruit and vegetable consumption
12. Proportion of persons at risk of long-term harm from alcohol
13. Proportion of children with all developmental health checks
14. Cancer screening rates for national programs
15. Low birthweight infants, by Indigenous status
16. Immunisation rates
17. Public health program expenditure as a proportion of total health expenditure

#### **Access**

18. Access to GP type services provided through MBS
19. Access to specialists
20. Access to acute care public and private hospital services
21. Access to sub-acute hospital services by care type (rehabilitation, palliative, GEM, psychogeriatric, maintenance, other) and whether public and private
22. Access to emergency department services by triage category
23. Access to prescription drugs
24. Access to dental services
25. Access to pathology and imaging services
26. Access to allied health services
27. Access to alcohol and other drug treatment services 84
28. Access to community mental health services
29. Access to optometry services
30. Selected potentially preventable hospitalisations (for ambulatory care sensitive conditions)
31. Potentially avoidable hospital emergency department attendances
32. Waiting times for elective surgery
33. Waiting times in emergency departments
34. Waiting times for GPs
35. Waiting times for public dentistry
36. Proportion of the population with severe mental illness receiving mental health care

- 37. Residential and community aged care services
- 38. Hospital use by patients waiting for residential aged care
- 39. Out-of-pocket costs as a proportion of cost of service (GP and specialist medical services, pharmaceuticals and dental services)
- 40. Deferment of required treatment due to cost

### **High quality—Appropriate**

- 41. Proportion of people with diabetes mellitus who have received an annual cycle of care within general practice
- 42. Proportion of people with diabetes mellitus who have an HbA1c (glycosylated haemoglobin) below 7%.
- 43. Proportion of pregnancies with an antenatal visit in the first trimester
- 44. Cancer survival
- 45. In-hospital mortality for selected procedures
- 46. Asthmatics with a written asthma plan
- 47. Unplanned hospital readmissions
- 48. Health and aged care service providers that are accredited

### **High quality—Safe**

- 49. Adverse drug events
- 50. Staphylococcus aureus (including MRSA) bacteraemia in acute care hospitals
- 51. Pressure ulcers in care settings
- 52. Fall resulting in patient harm in care settings
- 53. Intentional self-harm in hospitals<sup>2</sup>
- 54. Independent peer review of surgical deaths
- 55. Admitted adult patients who are assessed for risk of venous thromboembolism

### **Integration and continuity of care**

- 56. Discharge summaries transmitted electronically
- 57. Discharge plans for patients with complex care needs
- 58. General practices with register and recall systems for patients with chronic disease
- 59. Post-discharge community care for mental health patients

### **Patient-centred**

- 60. Patient experience

### **Efficiency/value for money**

- 61. Cost per case mix-adjusted acute care separation for acute care hospitals
- 62. Total cost per medical specialist (MBS) service

### **Sustainable**

- 63. Graduates in pharmacy, medicine and nursing as a percentage of the total pharmacy, medical and nursing workforce
- 64. Percentage of health practitioners aged 55 years and over
- 65. Commonwealth/States/Territories expenditure on health & aged care as a % of GDP
- 66. Number of accredited and filled clinical training positions
- 67. Capital expenditure as a proportion of total health and aged care expenditure
- 68. Proportion of GDP (or health expenditure) spent on health research and development

## Attachment 2

### *Examples of good practice provided to the Review*

The following table is a listing of good community health practice models and interventions that the Review was informed about by submissions, via the blog, in emails and in consultation sessions. This is not a complete or comprehensive listing of all good practice models and interventions as resources in the sector for data collection and analysis, preparing reports and making presentations are extremely limited. The list in the table represents models that have been offered to the Review and includes those with references to reports and different levels of documentation.

The compendium listings (CHETRE for NSW Health, the NSW Health Awards and Expo site with links to the ARCHI website, Strong Men, Deadly Groups, the Falls Network and HealthOne) each contain many examples of service delivery models. The selected models use approaches for which there is a well established or an emerging evidence base and are underpinned by primary health care principles.

CHETRE (2005) groups the projects into prevention & early intervention, ongoing care for chronic conditions, generalist/specialist interface and alternatives to hospitalisation. That selection illustrates the mix of functions, from the contribution of generalist primary health care services and integrated approaches across the range of primary health care providers and with more specialised health services. The NSW Health Baxter Awards web site hosted by ARCHI contains a large number of entries relating to good community health practice grouped under each year of the Awards (e.g. 2007 <http://www.archi.net.au/e-library/awards/awards07>).

The table includes a mix of examples from the community health streams and across the continuum of HRGs. The examples cover the full range of population groups (HBGs) in metropolitan, regional, rural and remote areas in NSW. The list has associated links to documentation and other models are listed in Section 9.3 on safety and quality systems.

**Table 4**      *Good practice models (selected listing)*

Model/Title of Project	Description	Source
<b>Compendia of models</b>		
Primary & Community Health Good Practice Models in NSW (CHETRE, 2005)	Lists a selection of good practice service delivery models that illustrate the mix of functions, the contribution of generalist primary health care services and integrated approaches across the range of primary health care providers and with more specialised health services:  Mobile Therapy Outreach Team; Kadeekamballa Clinic; Home Visiting; Aboriginal Health-Link; Mental Health Integration; Acute & Post Acute Care	Centre for Health Equity, Training, Research & Evaluation September 2005  Prepared for NSW Health.
NSW Health Baxter Awards web page with links to the ARCHI website	Twenty one entries for the 2008 Awards are grouped under each of the seven category headings of:  Make prevention everybody's business.  Create better experiences for people using health services.  Strengthen primary health and continuing care in the community.  Build regional and other partnerships for health.  Make smart choices about the costs and benefits of health services.  Build a sustainable health workforce.  Be ready for new risks and opportunities.	<a href="http://www.awards-expo.health.nsw.gov.au/awards">http://www.awards-expo.health.nsw.gov.au/awards</a>
Strong Men, Deadly Groups: Developing Healthy Communities.	Project supported by the Aboriginal Health and Medical Research Council of NSW, The Men's Health Information and Resource Centre at the University of Western Sydney and the NSW Department of Health.	<a href="http://www.ahmrc.org.au/amh/amh/">http://www.ahmrc.org.au/amh/amh/</a>

Model/Title of Project	Description	Source
Aboriginal Men's Groups Directory	<p>The DVD illustrates a sample of projects from the Directory. The Directory contains 31 local projects listed by region and giving the aims, venues, contact details and brief descriptions.</p> <p>Projects address cultural identity, land and community support issues, fatherhood and inter-generational issues, peer support, parenting strategies, anger management and family violence, sexual health, gay and bi-sexual issues, criminal justice and detention issues, mental health, depression and suicide, drugs and alcohol, smoking and healthy lifestyles, preventive health checks, live-in retreats, fishing, cooking and camping, spiritual therapy, arts and culture, employment and financial issues.</p>	<p>DVD and Directory.</p> <p>Consultations and Submission to the NSW Community Health Review</p>
Youth Health Models: New South Wales Centre for the Advancement of Adolescent Health (NSW CAAH), The Children's Hospital at Westmead.	<p>CAAH has sponsored a review of innovative health services for homeless young people by Community Link Australia Community Link Australia (2003), a research study on access to health care among young people in NSW called 'Better Practice in Youth Health' Kang et al. (2005), 'Better Practice Framework Factsheets' NSW CAAH (2006), and 'Young People's Access to Health Care: Exploring Youth Health Programs and Approaches in NSW' NSW CAAH (2005).</p>	Submission to the NSW Community Health Review
The Falls Prevention Program	<p>State-wide network of projects forming links with other agencies to build a network of physical activity programs (community and home-based) with a focus on strength, flexibility and balance training.</p> <p>Working with GPs, NSW Ambulance, Community Health teams and community service providers to identify people at risk of a fall and to implement a range of interventions appropriate for that person.</p> <p>The Network website provides community information on projects and good practice and access to research on the benefits of physical activity that promotes independence and positive ageing.</p>	<a href="http://www.cec.health.nsw.gov.au/moreinfo/falls.html">http://www.cec.health.nsw.gov.au/moreinfo/falls.html</a>
HealthOne NSW NSW Government initiative to integrate primary health care and community health to better meet the health needs of people in NSW.	<p>HealthOne NSW services are bringing together GPs and community health and other health care providers in 'one stop shops' and focus on keeping people well and out of hospital through prevention of disease and ill health, early intervention strategies and continuing care for people with chronic illness as well as providing GP and community health services.</p> <p>Integration underpins the model of care, delivered by all the health care professionals in the HealthOne NSW service working as a multidisciplinary team. Services may choose different governance arrangements, but all arrangements are expected to support the concept of team-based care and the integration of services.</p>	<a href="http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp">http://www.health.nsw.gov.au/initiatives/healthonensw/index.asp</a>
The Greater Metropolitan Clinical Taskforce (GMCT) Consumer and Community Participation	<p>The GMCT has over 30 consumer and community participants as active partners with clinicians across the GMCT Specialty Service Networks, to ensure that high quality care is delivered, access is improved and specialty services are well coordinated. Consumer and community participants often play key roles in their networks - chairing committees, contributing with first hand experience to the publication of patient guides (e.g. on kidney donation, bone marrow transplants and gynaecological oncology) or to planned media activities. In particular, their involvement helps to ensure that clinical discussions remain patient focused. The GMCT booklet, Guidelines on Consumer and Community Participation provides information about the role of consumer and community participants</p>	<a href="http://www.health.nsw.gov.au/resources/gmct/guidelines_consumer_pdf.asp">http://www.health.nsw.gov.au/resources/gmct/guidelines_consumer_pdf.asp</a>
<b>Aboriginal Health</b>		
Using knowledge to safeguard our nations - A collaborative approach to vascular and renal health in Aboriginal communities within the Countries of north-eastern NSW	<p>This was a collaborative approach to vascular and renal health in Aboriginal communities within the countries of north-eastern NSW.</p>	<a href="http://www.archi.net.au/e-library/awards/awards07/experiences/knowledge">http://www.archi.net.au/e-library/awards/awards07/experiences/knowledge</a>
Shake A Leg: New England Area Health Service (AHS) - Aboriginal Health in partnership with Awabakal Medical Service (AMS) - a school based Aboriginal Health Promotion	<p>Consultation with local Aboriginal communities in 2000 identified health education and promotion as a high priority for young people. The program utilises existing resources some specific to Aboriginal People others are mainstream resources delivered in a culturally sensitive way. The program is delivered by Aboriginal Health workers both from the AHS and AMS. Staff will be trained and time tabled according to the topic and the expertise of staff. The program is delivered in 40 minute sessions, 1 session per week for 10 weeks. It is written to meet key content areas of the school curriculum in Physical Education,</p>	<a href="http://www.nchn.org.au/projects/0507/aboriginal.htm">http://www.nchn.org.au/projects/0507/aboriginal.htm</a>

Model/Title of Project	Description	Source
Package.	Personal Development, Health and Welfare.	
Clearing the Tracks: Aboriginal paediatric clients' access to community health services in Quirindi and surrounding districts	A project educating the families and carers as to services provided and roles of Paediatric CH service providers and educating referring agents it was anticipated we would see an increase in referrals of Paediatric aboriginal clients to Quirindi CH	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
La Perouse Midwifery Project	The development of the model has been informed by results from pilot studies testing similar principles including an Illawarra model that has been evaluated and demonstrated useful outcomes for participants. This project supports pregnant Aboriginal women, focusing on those with higher risk factors who are offered continuous care throughout the pregnancy and birth and into infancy.	<a href="http://chsd.uow.edu.au/Publications/2005_pubs/Midwifery%20Group%20Practice%20Evaluation_CHSD.pdf">http://chsd.uow.edu.au/Publications/2005_pubs/Midwifery%20Group%20Practice%20Evaluation_CHSD.pdf</a>
Establishment of the Armidale Aboriginal Mothers and babies Service	The Aboriginal Mothers and Babies Service engages pregnant Aboriginal women or women who are partners of Aboriginal men who are not accessing mainstream services and/or who experience a range of social and economic difficulties or geographic isolation.  The Aboriginal Mothers and Babies Service provides a holistic, integrated and culturally appropriate model of care to Aboriginal women through pregnancy and 3 months post partum care.  The service embraces the principles of integrated perinatal care which includes appropriate referrals to other relevant agencies such as community agencies, Child and Family Health services, Alcohol & Other Drugs, Mental Health Services.	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
Guyra Aboriginal Community Health Newsletter	An ongoing newsletter on topics that specifically effected Aboriginal people in the community was established to inform the Aboriginal people of the Guyra Community of what services can be provide to them and what other services they can benefit from here at the Guyra Multi Purpose Service. From these newsletters Aboriginal people of all ages are accessing the services as well as the other services and now have a genuine interest in controlling their own health	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
Life smiles 4 Koori Kids. (An Oral Health Program for Aboriginal Children)	Life smiles 4 Koori Kids (LS4KK) program was developed collaboratively with the aim of improving the oral health of the aboriginal children of Greater Albury Cluster. Staff members of Albury Wodonga Aboriginal Health Service (AWAHS) are trained in promoting oral health in house and at schools in a culturally appropriate manner. AWAHS facilitate access to oral health services, liaising with stakeholders and providing transport. Dental time is dedicated so that LS4KK appointments have priority on certain days. Partnerships, skills and resources shared have resulted in productive use of clinician's time, culturally appropriate services, positive community response, improved oral health outcomes for the children.	<a href="http://www.awards-expo.health.nsw.gov.au/awards/category_4">http://www.awards-expo.health.nsw.gov.au/awards/category_4</a>
<b>Ageing and older people</b>		
Model of Wellness Centres/Activities for Older Women developed by the Older Women's Network (OWN).	The Wellness program has been operating successfully since 1995 providing support, services, training and capacity building strategies to over a thousand of older women across NSW. OWN NSW currently provides community services through their Wellness program to more than one thousand 50+-year-old women. The Wellness program runs activities that promote physical and mental health, stimulate social interaction and counteract isolation. "Kicking Up Autumn Leaves" is an evaluation of the wellness model and "A Picture of Wellness: The Story of the Bankstown Older Women's Wellness Centre" describes the origin of the model	Submission to the NSW Community Health Review by the Older Women's Network NSW Inc  <a href="http://www.ownnsw.org.au">www.ownnsw.org.au</a>
DADHC Access Point Demonstration Project for HACC services in the Hunter	This is a Commonwealth funded trial to improve the efficiency of assessment using electronic referral and a screening tool (the ONI-N) and telephone triage. The service has completed over 5000 assessments and the independent evaluation is expected to be useful in improving the system and drawing out lessons for wider system reforms. There are indications that broad community care assessment before an ACAT assessment may be more efficient and reduce waiting lists.	Submission to the NSW Community Health Review by the department of Ageing, Disability and Home Care.
Narrabri Arts and Dementia "Creativity and the individuality" Exhibition	the aim of raising public awareness of Dementia, facilitate an Art Exhibition of works created by Namoi Valley Aged Care residents with the assistance of local artists. The art exhibition also provided an opportunity to raise awareness of dementia through information sharing, provision of written material and oral presentations	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
EDuCARE - meeting the complex needs of carers	EDuCARE offers carer education programs, access to carer support, staff education on carer needs, developing and implementing carer	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>

Model/Title of Project	Description	Source
	friendly practices within the acute hospital and community settings and building partnerships with other service providers and GPs	<a href="#">7259/2008 HNEH Quality Award Entries.pdf</a>
Physical Activity Leaders Network	Physical activity programs designed to improve balance, strength, mobility, fitness and bone density have been identified as primary prevention strategies to reduce falls injury. One of the barriers to implementation of evidence based population health falls prevention interventions of this nature is the lack of a suitable delivery system. Rurality, large geographic distances and limited exercise providers complicate the implementation of low cost, accessible fall- safe activities. The Physical Activity Leaders Network (PALN) is a support strategy designed to train and support community volunteers to deliver effective fall-safe physical activity classes in areas with low population density. Preliminary data suggests volunteers are willing to provide low cost activities in their communities and the target population are supportive of localised strategies.	<a href="http://www.awards-expo.health.nsw.gov.au/awards/category_1">http://www.awards-expo.health.nsw.gov.au/awards/category_1</a>
Benevolent Society of NSW and the Social Policy Research Centre – a resource for community aged care workers and managers	These briefings draw on the existing research with a strong focus on what the research says about the value of existing practices and suggestions for improving practice. The first briefing examines the day-to-day working practices of paid community care workers with a focus on how care workers and managers can best support and enable good care of older people living in their own homes.	Caring for older Australians: Care workers and care practices that support and enable good care.  Research into Practice Briefing No.1 <a href="http://www.bensoc.org">www.bensoc.org</a>
<b>Mothers, babies and children</b>		
Belmont Birthing Service	It is a stand-alone midwifery led birthing service, located within Belmont Hospital, but essentially functions as a primary health care model of maternity care in line with community health philosophy. Community development, primary health care and health promotion are the principle strategies.	<a href="http://www.phaa.net.au/documents/Dec07.pdf">http://www.phaa.net.au/documents/Dec07.pdf</a>
Early Bird Program	This model is the Early Bird Program where mothers are brought into the service in the first week after they leave hospital, and issues can be addressed including breastfeeding and mental health, and the culture established of mothers coming back to us on a weekly basis up to the infants' age of 6 months.	<a href="http://nswchr.wordpress.com/nsw-community-health-review-2008/">http://nswchr.wordpress.com/nsw-community-health-review-2008/</a> - comment-9  Submission to the NSW Community Health Review
NCAHS Active School Kids Project	School based project where students identify barriers to physical activity, investigate and propose solutions, devise budget and apply to the AHS for small grant, implement projects to increase physical activity levels	<a href="http://www.ncahs.nsw.gov.au/healthy-weight/index.php?pageid=3044&amp;siteid=198">http://www.ncahs.nsw.gov.au/healthy-weight/index.php?pageid=3044&amp;siteid=198</a>
'Big Steps, Little Steps' – A resource for young parents	A project was undertaken by the Young Parents Network (YPN) including young consumers and service providers to develop a resource book about pregnancy, birth and parenting. Involvement of young parents and service providers in the creation of the book led to a sense of shared ownership	<a href="http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
Tummy Rumbles Nutrition Education package	This program is a nutrition education package for childcare workers and carers of children 5 and under that is delivered by face-to-face training of children's services staff who then promote good nutrition to parents.	<a href="http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
NSW Travelsmart Schools Program 2006-2007 Summary Report	Collaboration between Health Promotion Service SSWAHS, NSW Premier's Council for Active Living, NSW Ministry of Transport, NSW Department of Environment and Climate Change and Sydney South Regional Organisation of Councils, funded by the Australian Greenhouse Office. Evaluation of a project to reduce car use and encourage active travel to and from school in 15 primary schools in Sydney's inner west and eastern suburbs showed the key limiting factor was the lack of multi-sectoral forum to resolve complex decision-making issues in urban design. Recommendations for designing and implementing active travel strategies.	Consultation and submission to the NSW Community Health Review from the Health Promotion Service SSWAHS
Newling Public School Speech and language Project	Due to the difficulties with access the children were seen at their local school and a small group was implemented by a teacher's aide targeting common goals to each of the students in the group. The program was designed and made by a speech pathologist and training was provided to the teacher's aide	<a href="http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
Speech Pathology in Schools (SPinS)	A speech and language assessment tool was used to screen all kindergarten children across targeted primary schools within the Wagga area. The results were used to tailor an intervention program aimed at whole class participation, which was linked with the Kindergarten syllabus outcomes in the Board of Studies key learning areas. The classroom teachers, teacher's aides, and relevant language support personnel were trained by the Speech Pathologist on implementing this program, and targeting speech and language	<a href="http://www.awards-expo.health.nsw.gov.au/awards/category_3">http://www.awards-expo.health.nsw.gov.au/awards/category_3</a>

Model/Title of Project	Description	Source
	goals within the curriculum. Post assessment of the children occurred approximately six months after initial testing, and revealed the participants improved across all measured areas of speech, language, vocabulary, and sound awareness tasks.	
Mt Druitt Sustained Home Visiting Program (SHVP)  Epidemiology, Population Health and Strategic Direction, Sydney West Area Health Service 2007	The Mt Druitt SHVP is an innovative pilot program funded through the Mt Druitt Community Solutions and Crime Prevention Strategy (MDCS&CPS). The two key principles underpinning the MDCS&CPS initiatives are: the need for improved linkages between services; accessing disadvantaged families outside the current service networks.  The team is made up of Child and Family Health Nurses (C&FHN) and community volunteers, and operates out of Mt Druitt Community Health Centre (MDCHC). The Mt Druitt community was targeted in response to the current social and economic disadvantage experienced by the community. It requires a dedicated researcher to work with the team to assist with the evaluation and to maintain data quality. Fewer data requirements for future programs would help.	Consultation and submission to the NSW Community Health Review from SSWAHS
Mobile Outreach Therapy Team (MOTT)	MOTT is a project of Mt Druitt Community Health Centre (Child and Family Team) funded by the Community Solutions and Crime Prevention Strategy. It aims to improve the school readiness of children from vulnerable families. The home-based therapy service targets the development of a child's skills in: speech; language; motor co-ordination; self care; play and behaviour. The program targets aspects that contribute to a child's school readiness.	Consultation and submission to the NSW Community Health Review.  Mobile Outreach Therapy Team, Evaluation Report, November 2007.
<b>Chronic disease</b>		
Area-Wide HIV Community Team, South Eastern Sydney Illawarra Health	Refocusing the health care needs of people living with HIV to an approach with a chronic disease management emphasis. Four different levels:  Population health  Primary and Community Health  Complex Care  Acute Care	<a href="http://www.nswchr.net/Home/Submissions/submissions-2/04-SubmissionHCTModelofCareCHRSep08.pdf">http://www.nswchr.net/Home/Submissions/submissions-2/04-SubmissionHCTModelofCareCHRSep08.pdf</a>  Submission to the NSW Community Health Review
Respiratory Coordinated Care Program (RCCP) - Division of Medicine St George Hospital	Hospital based service that provides co-ordinated care to people with respiratory problems. Two components- chronic for long term, chronic patients and acute for, short term, early discharge patients. The model of care incorporates a collaborative approach between health professionals i.e. respiratory physicians, GPs, nurses, allied health and community services, to help achieve the desired outcome	<a href="http://www.nswchr.net/Home/Submissions/submissions-2/07-RCCPStats1998to2007.ppt">http://www.nswchr.net/Home/Submissions/submissions-2/07-RCCPStats1998to2007.ppt</a>  Consultation and submission to the NSW Community Health Review
Ring O'Rosies Mass Vaccination Clinic Exercise	Hunter New England Health conducted a mass vaccination clinic exercise in a rural Upper Hunter postcode during March 2008 with 498 individuals vaccinated with the 2008 influenza vaccine. The mass vaccination exercise was an Australian-first.	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
From Little Things – Big Things Grow	The programs were designed to educate the community on available options in reducing the incidence of obesity in an effort to prevent or delay the onset of chronic diseases, these programs needed to be affordable and accessible to all community members. Funding to install a walking track and fitness stations within a local park was secured through external sources, whilst physical activity classes were established through the health service	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
<b>Hospital demand management</b>		
Paediatric Ambulatory Care – The way of the future - NSCCAHS	Hospital admission is potentially very stressful for unwell children and their families <sup>1</sup> . Innovative new paediatric models of care have been established at Wyong and Hornsby Hospitals in the last 2 years. Both models incorporate Paediatric Acute Review Clinics (PARC).  This model of care provides an alternative to inpatient admission for acutely unwell children. Care is provided by specialist paediatric medical and nursing staff in daily acute review clinics. The care provided has led to reduced hospital admissions and high levels of patient / parent satisfaction. There is potential for this model of care to be implemented widely across the state in the future.	<a href="http://www.awards-expo.health.nsw.gov.au/awards/category_2">http://www.awards-expo.health.nsw.gov.au/awards/category_2</a>
Hunter Referral and Information Centre	Centralised telephone access point to all Newcastle Community Health services. The RIC aims to improve access to timely, safe, consistent and appropriate level health care information, support and advice to clinicians and the community.	Clinical Services Redesign Program, Referral and Information Centre, NSW Department of Health, Sydney 2006

Model/Title of Project	Description	Source
Alternatives to Acute Hospital – APAC/GP Shared Care	The Shared Care model was initiated in 2006/2007 in response to increasing demand on Emergency Departments (EDs) and the growing number of elderly patients, with ambulatory sensitive conditions, being admitted to hospital. The APAC/GP Shared Care Program has enabled people using public health services to experience a care option, in their own home, that is underpinned by primary health care principles. Redesign of the APAC service to include GP direct referral reflects a better pathway of access to care.	<a href="http://www.awards-expo.health.nsw.gov.au/awards/category_3">http://www.awards-expo.health.nsw.gov.au/awards/category_3</a>
The Greater Newcastle Cluster Wound Management Model Redesign Journey	In 2005, 2006 and 2007 the Greater Newcastle Cluster (GNC) conducted a point prevalence study across six community health centres. Data collected investigated the number of clients with a wound, the type and healing rate. Changes in wound care practices and service delivery were implemented, resulting in improved health outcomes for clients with a non healing wound rate falling from 44 per cent to 11 per cent.  The 2007 study also identified the co-morbidities which delayed or prevented the healing of wounds. Further changes have been implemented identifying clients with high-risk delay wound healing and initiating earlier proactive interventions with referral to specialised care. While wound care referrals have increased, consumable and staff cost per patient have decreased significantly improving productivity.	<a href="http://www.awards-expo.health.nsw.gov.au/awards/category_3">http://www.awards-expo.health.nsw.gov.au/awards/category_3</a>
<b>Palliative care</b>		
Improving medication safety for palliative care clients and their carers in the home setting	It outlines the process involved in: establishing a carer's preparedness to administer subcutaneous medication; a carer education tool; a protocol for staff to outline the system and process. The outcomes of the project demonstrated that carers were trained to safely administer subcutaneous medication and there were no medication errors	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf</a>
Laundry Consortium: Smart costs benefits to the community	Laundry facilities are provided from the Dungog Community Hospital site to provide the Palliative Care Volunteer Group a free linen service to Palliative Care patients at home. It now includes other disadvantaged members of the Dungog Community	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf</a>
<b>Pain</b>		
Educating Clients in Community to Manage Persistent pain	The Westlakes Community Rehabilitation Unit staff, together with feedback from clients identified a need for a multidisciplinary pain management educational program for clients living in the community. The staff, with assistance from The Hunter Integrated Pain Service and key stakeholders, developed an educational pain management program called "Learn About Pain". The completion of two six-week programs and a three-month review have provided pleasing feedback from clients	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf</a>
Evidence based pain management for community delivery	Moving with Pain (MWP) is a standardised reactivation program that blends interactive behavioural modification therapy (IBMT) with educational messages around pain (Leeuw et al. 2007, Woby et al. 2007). is delivered at the Hunter Integrated Pain Service (HIPS) by specialist physiotherapists and nurses. HIPS has studied the outcomes (both physical and psychological) and found the program to be efficacious as well as safe and client centred. The group format delivery of services allows timely access to pain management strategies.	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/3/7259/2008_HNEH_Quality_Award_Entries.pdf</a>
<b>Psychosocial</b>		
Men's Health Officer Network. Men's Health Information and Resource Centre at the University of Western Sydney	Involved in State, AHS and local Men's Health strategic planning Prostate cancer support nursing Homeless persons support nursing and advocacy Health professional and public education and awareness Research and producing appropriate resources	<a href="http://menshealth.uws.edu.au/">http://menshealth.uws.edu.au/</a> <a href="http://www.menshealthaustralia.net/">http://www.menshealthaustralia.net/</a> Consultation and submission to the NSW Community Health Review
St George Domestic Violence Counselling Service	This model takes a human rights and a strengths-based approach. The impact of violence on women and children is named as a primary cause of ill health both physical and mental. Effects of trauma are addressed in a therapeutic context while avoiding further negative stereotyping of those who are affected by violence.  Strategies are identified and built on in a collaborative approach between worker and client. A "deficit" model is avoided  A range of modalities is used. Advocacy with legal and other services	<a href="http://www.nswchr.net/Home/Submissions/submissions-available/18-STGDVCS.pdf">http://www.nswchr.net/Home/Submissions/submissions-available/18-STGDVCS.pdf</a> Submission to the NSW Community Health Review

Model/Title of Project	Description	Source
	<p>is a strong feature of this work. Other direct service modalities are counselling and group work</p> <p>In accordance with the social model of health and analysis of domestic violence the team addresses the issue of domestic violence in a broader context. This involves community development, community education, professional education to Universities and other professional bodies, research, mentoring and supervising other service providers.</p>	
Port Macquarie/Hastings Domestic Violence Support Project	<p>The project provides a planned and collaborative approach to early intervention support through a formalised inter-agency service agreement to provide information, support and referral to victims of domestic violence.</p> <p>Outcomes include a significant increase in the number of women seen for early intervention support and information; improved inter agency relationships with local police and increased referral to support services; contact with women who had not previously sought advice; and a significant reduction in the number of repeat events per victim of domestic violence compared to other locations in the Police Area Command.</p>	<a href="http://www.awards-expo.health.nsw.gov.au/awards/category_4">http://www.awards-expo.health.nsw.gov.au/awards/category_4</a>
The Mt Druitt Family Violence Response & Support Strategy (FVRSS)	FVRSS is one of the largest of a package of initiatives for Mt Druitt funded through the Community Solutions and Crime Prevention Strategy for five years. It is a partnership between the Department of Community Services (Metro West Region), NSW Police (Mt Druitt Local Area Command) and NSW Health (Sydney West Area Health Service), in collaboration with other government agencies and non-government organisations. The Department of Community Services (DoCS) is the budget holder. There are five key components: Mt Druitt Family Violence Service (FVS); Aboriginal Women's Resource and Development Centre project, (Mirang Din); Interagency Training Plan; Brokerage/Specialist Services; Partnership Model	<p>Consultation and submission to the NSW Community Health Review</p> <p>Final Report: FVRSS Planning, Docs Metro West Region August 2007</p>
Nowra CHC: Redesigning Psychosocial Services: a way to radically improve access, interaction, reliability and vitality, all now gone, but not forgotten.	<p>The write up of the project described a process of continuous evidence based and integrated changes in the Psychosocial Service in Nowra from a baseline description and data from 1997 through to May 2001. Sadly and ironically, the service achieved greatly increased client loads and met best practice guidelines for clinical psychological disorders, but management continued in a system of rewarding only those services with waiting lists.</p> <p>Innovative efforts to improve service delivery in the workplace were rewarded with an award and photograph but punished with downgrading of service enhancements status. The net effect was discouragement of any future similar attempts.</p>	Submission to the NSW Community Health Review
Assessment of a proposal to create a performing arts centre within Hazelbrook Uniting Church	Hazelbrook community profile and needs assessment study to plan non-government initiatives for social inclusion and responding to social disadvantage. Recommendations on arts and cultural domain for youth, indigenous and disability benefit groups.	Submission to the NSW Community Health Review
Healthy Budget Bites healthy partnerships healthy communities	Funding enabled work with community service workers and volunteers to increase their capacity to deliver information surrounding healthy eating habits and low cost living with their client groups, within the Cessnock Local Government Area and to print the Healthy Budget Bites Cookbook and Training Resource.	<a href="http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
<b>Justice Health</b>		
Justice Health Statewide Service Delivery Model	<p>With just over one quarter of patients staying in custody for less than 8 days and just under 50% staying for less than 30 days, the priorities for Justice Health are to ensure the patient's immediate or acute health needs are met and to ensure that they remain safe and free from harm. The Justice Health Statewide Service Delivery model is focused on screening, triaging and providing care. "Reception Triage", provides health and risk assessments on patients entering New South Wales Correctional Centres.</p> <p>The Reception Triage Process is undertaken on all of the patients entering the New South Wales correctional system in three stages:</p> <ol style="list-style-type: none"> <li>1. Triage: all patients undergo a triage process to determine any immediate or acute health needs.</li> <li>2. Screen: all patients have a risk assessment undertaken to determine if they are at risk of harming themselves or being harmed by others.</li> </ol>	Consultation and draft submission to the NSW Community Health Review

Model/Title of Project	Description	Source
•Population Health	3. Comprehensive health assessment: any immediate health care needs are stabilised and appropriate health care referrals are made. This is a more detailed assessment that involves additional screening of targeted patients and the development of a management plan for their care.	
Connections Project  This project aims to improve continuity of care for recidivist clients of the correctional centres with drug and alcohol problems, who are being released to the community.	It is well known that post release clients with drug and alcohol issues experience difficulties in the return from prison to the wider community. These include dealing with a range of negative experiences of imprisonment. These experiences are characterised by isolation, accommodation difficulties, financial and material constraints and a lack of significant emotional support. In addition, recent research has shown that clients released from NSW prisons have a substantially higher risk of mortality post-release from a range of causes (especially drug overdose) than the general population.  The Connections Project utilises a broad array of contacts, both in the correctional environment and the community, and links clients to relevant health and welfare service providers appropriate to their individual needs post release.	Consultation and draft submission to the NSW Community Health Review
Statewide Court Liaison Service  There are Justice Health mental health practitioners in 17 courts across NSW and 2 courts provide the service through Telehealth	This service provides mentally ill offenders with court-based diversion options from the criminal justice system towards treatment in mental health facilities.  During 2007-08, 14,746 clients were screened for mental health problems. 1,990 clients received a comprehensive mental health assessment, of whom 1622 were found to have a mental illness. 71 per cent of those persons were diverted from the criminal justice system into community care or mental health facilities.	Consultation and draft submission to the NSW Community Health Review
Adolescent Youth Drug and Alcohol Court, Court and Community Team	Adolescent Health provides services to the Youth Drug & Alcohol Court (YDAC) program including physical, mental and drug and alcohol health assessments, working closely with Department of Juvenile Justice (DJJ), Department of Community Services (DoCS) and Department of Education and Training (DET).  This service is aimed at clients between the ages of 10 and 18 years who have come in contact or are at risk of contact with the criminal justice system and have an existing or emerging mental illness and/or drug and alcohol problems. The service has four main components: community based assessments and linking to appropriate community services; court liaison and diversion; discharge planning for young people in custody and for some young people occupying mental health inpatient beds; and case management of a small number of clients.	Consultation and draft submission to the NSW Community Health Review
Adolescent Health also operates the Community Integration Team.	This project involves assessing post release needs prior to release from custody and developing a post release care plan to assist with co-ordination between custodial care and community based health and welfare services. The aim of this programme is to support young people to stay in the community for longer, support the re-integration back into their family network where appropriate and to enhance support to individuals with drug problems post release.	Consultation and draft submission to the NSW Community Health Review
Community Forensic Mental Health Service  At 30 June 2008, the CFMHS had 43 civil patients and 107 forensic patients comprising of 94 conditionally released patients in the community and 13 forensic patients in custody	This service provides specialist forensic assessments and advice for individuals with a serious mental illness presenting to the criminal justice system. The service has an ongoing role in monitoring and reviewing conditionally released patients in the community of which there are approximately 80 at anyone time. The service also collaborates with the Department of Corrective Services in the provision of treatment to sex offenders in custody and in the community.  The Sexual Behaviours Clinic for the treatment of sex offenders operated at capacity with 65 open cases, including persons on extended supervision orders (ESO) under the Crimes (Serious Sex Offenders) Act 2006	Consultation and draft submission to the NSW Community Health Review
<b>Homelessness</b>		
The Housing Accommodation Support Initiative	The Housing Accommodation Support Initiative (HASI) has shown effective community based mental health services can lead to improved circumstances for clients. HASI is a partnership between the NSW Department of Housing, the NSW Department of Health and the mental health non-government sector. Departments are funding the evaluation from the Social Policy Research Centre	<a href="http://www.health.nsw.gov.au/pubs/2007/hasi_evaluation.html">http://www.health.nsw.gov.au/pubs/2007/hasi_evaluation.html</a>  SPRC Reports 1/07 and 13/8 Consultation with Areas and Social Policy Research Centre
NSW Housing and Human Services Accord	The purpose of the Accord is to improve planning, coordination and delivery of services to assist social housing tenants sustain their	Submission to the NSW Community Health Review from

Model/Title of Project	Description	Source
(2007)	tenancies, as well as to facilitate community building and to reduce social disadvantage in larger social housing areas. The Accord can act as the main mechanism through which clinical and social support services will be coordinated and delivered to social housing tenants.	Housing NSW,
NSW Housing and Human Services Accord Shared Access Schedule (2008)	Shared Access Trials have been established in Gosford, Newcastle and Nowra for people with co-existing disorders to link Housing NSW with NSW Health, Corrective Services, Justice Health and DADHC.  Liverpool – Fairfield has a housing and support pilot for ex-prisoners with dual diagnosis established under the Accord.	Submission to the NSW Community Health Review from Housing NSW,
<b>Drugs and alcohol</b>		
North Coast Area Health Service Cannabis Clinic Operational Guide	The development of the NCAHS Drug and Alcohol Service Cannabis Clinic model has been informed by results from pilot studies already undertaken elsewhere in NSW and treatment is based on CBT principles consistent with available evidence.  Clinicians are located in the most appropriate geographical locations throughout the Area Health Service in an effort to respond equitably to the needs of cannabis users, parents and carers and other interested agencies in a regional/rural setting.  The operational guide details the clinical governance of the NCAHS Cannabis Clinics Program. This guide is to be read in conjunction with existing policies and procedures of the North Coast Area Health Service.	Submission to the NSW Community Health Review from Area Drug and Alcohol Director
Sutherland Cannabis Clinic	Sutherland Cannabis Clinic is out in the community, and therefore discreet for clients to attend. It targets a specific group, which in itself supports marketing to raise community awareness of the service, and it is an appropriate outpatient treatment for the issue, with a good success rate.	Submission to the NSW Community Health Review  <a href="http://nswchr.wordpress.com/nsw-community-health-review-2008/">http://nswchr.wordpress.com/nsw-community-health-review-2008/</a> - comment-8
Drugs in Pregnancy Program (MUMS)  A Guide for Case Managers	Developed in partnership by the Women's Referral and Access Project (WRAP), Tweed, Richmond and Clarence Valley MUMS Drugs in Pregnancy Teams and Area Drug and Alcohol Clinical Nurse Consultants. In response to an identified need and gap in services for pregnant women and new mothers with substance use issues in the North Coast Area Health Service, health professionals formed multidisciplinary teams and established a drugs in pregnancy (DIP) service also known as MUMS.  Contains information to guide the role of the case manager and where case managers can access support. Describes the processes and forms required for intake, admission, assessment, referral, brokerage, case review and discharge from the program.	Submission to the NSW Community Health Review from Area Drug and Alcohol Director
<b>Rural communities</b>		
Community Hearing Services In NSW Health	This program, which is conducted at field days across NSW provides farmers and farm families with access to hearing screening services, education and information on prevention of rural noise injury. To date almost 20,000 farmers have accessed this service.	<a href="http://www.nswchr.net/Home/Submissions/submissions-2/06-COMMUNITYHEARINGSERVICESINNSWHEALTH.pdf">http://www.nswchr.net/Home/Submissions/submissions-2/06-COMMUNITYHEARINGSERVICESINNSWHEALTH.pdf</a>  Submission to the NSW Community Health Review
InFARMed improving Farmers Access to Health Services	Strategies were developed for farmers to improve community linkages, information exchange within rural services, mental health first aid training and health service data mining. The data mining snapshot data of 131 farm family clients reveals referrals to Community Health Services have doubled after the formation of the network.	<a href="http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>
<b>Refugee and multicultural communities</b>		
Croatian Needs Assessment in Fairfield LGA	Planning model project based for Fairfield LGA investigated the health issues and community needs of the ageing Croatian population. Analysis of needs indicates problems in access and cultural competencies of mainstream services. Includes recommendations for improved service responses for a small but high need group.	Submission to the NSW Community Health Review from Fairfield Multicultural Health Service multicultural health worker
Building a refugee health service for the Northwest	In November 2006, Hunter New England Health established a Refugee Health Service for refugees resettling in the region. Refugee Health Nurses' role in connecting support services, improving access to health services, and assistance with other health matters including diet and nutrition. Outcomes have included improvements in general health status, disease prevention, sustainable integration, and improved access through networks and education.	<a href="http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf">http://www.hnehealth.nsw.gov.au/data/assets/pdf_file/0008/37259/2008_HNEH_Quality_Award_Entries.pdf</a>

Model/Title of Project	Description	Source
Collaborative Care Model for Newly Arrived Refugee Families	In 2006/07, the GP-Hospital collaborative care model was created as a partnership between Sydney Children's Hospital, Wollongong Hospital, the SESIH Multicultural Health Service (MHS) and the Illawarra Division of General Practice (IDGP). The model places a network of refugee-friendly GPs at the centre of care for newly arrived refugee families.	<a href="http://www.phaa.net.au/documents/Dec07.pdf">http://www.phaa.net.au/documents/Dec07.pdf</a>
<b>Developmental and intellectual disability, life long illnesses and disabilities</b>		
The Kogarah model - a comprehensive array of integrated diagnostic, assessment, specialist and allied health clinics, and ongoing monitoring service for children, adolescent and adults with developmental disabilities.	<p>Many clinic services are provided in collaboration with DADHC, DET and ASPECT and are conducted off-site, such as in special schools.</p> <p>Clinics are offered on a local and area-wide basis (particularly in the Illawarra) according to the level of service demand and the degree of specialisation required. There is a link between child and adult services, allowing the more developed paediatric services to facilitate the development of transition services. Specialist clinic services are conducted in psychiatry, neurology, medical, rehabilitation, genetics, nutrition and other specialities and are staffed by paediatric and adult specialists.</p> <p>The model underpins the development of a network of specialist multidisciplinary services and creates opportunities for new innovative (often cost-neutral) services in response to the changing needs of the local community.</p>	Submission to the NSW Community Health Review from Dr Robert Leitner, Developmental Assessment Service, Division of Women's & Children's Health Services, Central Network, South East Sydney Illawarra Area Health Service
GMCT Transition Care Network and The Spina Bifida Collaborative – model of specialist care to meet the needs of adolescents and young adults with chronic life long illnesses and /or disabilities	The Spina Bifida Collaborative group applied for funding for two health workers, a clinical nurse consultant and an occupational therapist to form a state wide resource team for adults with Spina Bifida living in the community. This team will be located in the community in a health facility or with a NGO. The aim will be to network and support young people with Spina Bifida to access appropriate services and to support service providers with information and education to support the young person in their community. The local community health centre could provide a very valuable ongoing support service to young people with high support needs and significantly improve their health care and quality of life.	Submission to the NSW Community Health Review from the GMCT Transition Care Network. and Dr Carolyn West, Director Spina Bifida Unit, The Children's Hospital at Westmead.

## Attachment 3

### *Summary of community health by Area Health Service*

Table 5 and Table 6 summarises the community health service streams in scope for the Review and the service management arrangements for each stream in each metropolitan and rural Area. Attachment 4 provides the organisational charts for each Area.

**Table 5** *Metropolitan Community Based Service Stream Arrangements by Area*

Stream	HNE	NSCCAHS	SESAHS	SSWAHS	SWAHS
Aboriginal Health	PPP for Area Program with joint service delivery with P&CN for priority programs	PPP for Area Program with joint service delivery with P&CH for priority programs	PPP for Area Program with joint service delivery with community health and clinical streams	PPP for Area Programs. CH for targeted Aboriginal Child and Family and Chronic Disease programs	PPP for Area Programs with AHEOs and AHLOs also attached to CH teams
Aged & Extended Care	Area Service under umbrella of Primary & Community Network	Area Stream	Area Stream	Area Stream	Area Network
Child & Family Health	P&CN with Childrens Network Kaleidoscope	P&CH	CH in conjunction with Child & Adolescent Health Stream	CH	CH
Community Nursing & Domiciliary Care	P&CN	P&CH	CH	CH	CH
Community Rehabilitation	P&CN Aged Care and Rehabilitation Services plus CAPAC	P&CH APAC and Chronic and Complex Care teams plus Aged Care Stream	Clinical Stream – Aged & Chronic Care/Community Health in conjunction with Hospital Networks	Ambulatory programs through Acute Allied Health Directorate now in CH	CH & Chronic, Complex Aged Care Network and Rehabilitation Network
Counselling & Psychosocial Services	Limited in urban but CH is a key provider in rural communities	Generalist counselling for adults not provided.	Hospital Network service provision	CH targeted model within Child and Family Team	CH targeted brief intervention model within Child & Family
Drug & Alcohol	Area Service managed by P&CN	MHDA Area Program	MHDA Area Stream	MHDA Area Stream	MHDA Area Network
Health Promotion	PPP for Area programs targeting NSW Health and state priorities	PPP for Area programs targeting NSW Health and state priorities	PPP for Area programs targeting NSW Health and state priorities	PPP for Area programs targeting state priorities plus HUB Community Development in CH	PPP for Area programs targeting NSW Health priorities plus CH locality HPOs
Hospital Demand Management	P&CN manages CAPAC	P&CH manages Area APAC Service	Hospital Networks service provision in conjunction with CH	CH manages CAPAC for all hospitals except Campbelltown	Access and Patient Logistics Network for PAAC. CH for community chronic disease and diversion services
Intake and initial assessment	CH patients only with links with Patient Flow Units in Acute Hospitals	P&CH moving to single central intake service	CH patients only with links with Patient Flow Units in Acute Hospitals, moving to single central intake service in each Hospital Network	CHAIN Central Intake for CH	Centralised Intake for CH clients plus integrated dashboard for hospital diversion with Access and Patient Logistics

Stream	HNE	NSCCAHS	SESAHS	SSWAHS	SWAHS
Mental Health	MH&DA Clinical Network	MH& DA Stream	MHDA Stream	MHDA Stream	MHDA Network
Multicultural Health		P&CH	PPP plus multicultural staff in Hospital Networks	CH	PPP plus multicultural staff in CHS
Multidisciplinary Chronic Disease Management	Area Diabetes Service and multidisciplinary programs managed by P&CN	P&CH manages Area Chronic Disease Programs	CH with Aged & Chronic Care; Cancer; Acute; Cardiac; Medicine; Neurosciences/Rehabilitation; Rural Health Streams & Allied Health in Hospital Networks	CH with Acute and Sub Acute Streams	CH with Chronic, Complex and Aged Care; Cancer; Acute; Cardiac; Allied Health and Rehabilitation Networks
Oral Health	Area Service managed by P&CN	Area Program managed by P&CH	Area Network within Area Stream	Area Stream	Area Network
Palliative Care	CH with Area Cancer Service	Cancer Services	CH with Cancer Network	CH	CH with Cancer Network
Physical Abuse and Neglect of Children	P&CN with Kaleidoscope Childrens Network	P&CH	CH	CH	CH
Sexual Assault	Area violence prevention service managed by P&CN	P&CH	CH	CH	CH
Sexual Health	PPP	P&CH	PPP and Hospital Networks	CH	PPP and Infectious Disease Network
Women's Health	CH	P&CH	CH with Women's & Babies Health Clinical Stream	CH	PPP for Area Programs and CH for locality and target group services
Youth Health	CH	P&CH	CH in conjunction with Child & Adolescent Health Stream	CH	CH

**Table 6 Rural Community Based Service Stream Arrangements by Area**

Service Stream	GWAHS	GSAHS	NCAHS
Aboriginal Health	PPP for Area Programs with joint service delivery with CH for priority programs	PPP for Area Programs with joint service delivery with CH for priority programs	PPP for Area Programs with joint service delivery with C & A H for priority programs
Aged & Extended Care	CH	CH	C & A(IIed) H
Child & Family Health	CH	CH	C & A H
Community Nursing & Domiciliary Care	CH	CH	C & A H
Community Rehabilitation	CH and Hospitals	CH and Hospitals	C & A H and Hospitals
Counselling & Psychosocial Services	CH	CH	C & A H
Drug & Alcohol	MHDA Program	MHDA Program	Area Wide DAO program
Health Promotion	PPP	PPP	PPP
Hospital Demand Management	CH and Base Hospitals	CH and Base Hospitals	C & A H and Hospitals
Intake and initial assessment	CH	CH	C & A H
Mental Health	MHDA Program	MHDA Program	Area wide MH stream
Multicultural Health	PPP for Area Programs with joint service delivery with CH for priority programs	NA	Refugee health is PPP, rest is C & A H (very small)
Multidisciplinary Chronic Disease Management	CH and Hospitals	CH and Hospitals	C & A H and Hospitals- a little in PPP (eg falls)
Oral Health	Area Program	Area Program	Area stream
Palliative Care	CH	CH	Services delivered by C & A H – but Area Director of palliative care – who sets strategy
Physical Abuse and Neglect of Children	CH	CH	Services delivered by C & A H – but Area Director of palliative care – who sets strategy
Sexual Assault	CH	CH	C & A H
Sexual Health	CH	CH	PPP
Womens Health	CH	CH	C & A H
Youth Health	CH	CH	C & A H
			Floating

**Table 7 Divisions of General Practice Key Statistics 2006/07 by Area Health Services**

Name of Division of General Practice	Population 2006 <sup>B</sup>	Estimated number of Indigenous persons <sup>C</sup>	Population aged over 65 years <sup>D</sup>	Total number of practices	Solo practices	Estimated number of practising GPs	Number of female GPs	FWE GPs as at 30/06/06 <sup>E</sup>	Estimated number of GPs: population 2006 ratio	FWE GP: population 2006 ratio
<b>SSWAHS</b>										
Central Sydney Division of General Practice	380452	3961	41893	204	88	610	292	404	624	942
Canterbury Division of General Practice	143379	785	18420	95	72	152	Unknown	156	943	919
Bankstown General Practice Division	170078	1152	23246	94	52	154	46	221	1104	770
Liverpool Division of General Practice	168342	2419	14304	68	33	168	49	161	1002	1046
Fairfield Division of General Practice	216669	1489	23668	129	86	205	49	277	1057	782
Macarthur Division of General Practice	233071	5426	17684	87	47	205	39	243	1137	959
Southern Highlands Division of General Practice	49062	649	8267	18	7	58	25	37	846	1326
<i>Includes part NSW Central West</i>										
<b>SWAHS</b>										
Nepean Division of General Practice	176840	4183	14022	86	43	156	42	184	1134	961
Blue Mountains Division of General Practice	76080	985	9929	23	10	71	35	54	1072	1409
Hawkesbury-Hills Division of General Practice	251424	2717	20155	89	44	249	110	208	1010	1209
WentWest Ltd	468711	8745	47569	204	114	526	157	533	891	879
<i>Includes part NSW Central West</i>										
<b>NSCCAHS</b>										
Northern Sydney Division of General Practice	217073	317	27729	108	Unknown	332	200	204	654	1064
HKR Division of General Practice	417803	1055	57758	154	52	503	271	365	831	1145
Manly Warringah Division of General Practice	228978	748	32972	83	26	223	95	192	1027	1193
NSW Central Coast Division of General Practice	304274	6825	54057	92	36	294	84	281	1035	1083
<b>SESAHS</b>										
Eastern Sydney Division of General Practice	180806	961	20604	168	88	461	235	227	392	797
South Eastern Sydney Division of General Practice	191027	2823	24653	92	52	230	62	177	831	1079
St George Division of General Practice	231765	1141	34794	129	70	256	98	238	905	974
Sutherland Division of General Practice	212257	1304	27520	71	23	223	100	189	952	1123
Illawarra Division of General Practice	277972	5146	40797	87	36	243	62	267	1144	1041
Shoalhaven Division of General Practice	90868	3745	18740	36	16	106	37	77	857	1180
<b>HNEAHS</b>										
Hunter Urban Division of General Practice	457072	11141	68710	148	59	431	177	363	1060	1259
Hunter Rural Division of General Practice	206933	7181	35903	74	33	189	48	167	1095	1239
New England Division of General Practice	65646	3783	10169	29	11	63	25	51	1042	1287
North West Slopes (NSW) Division of General Practice	61662	4625	9186	26	16	53	21	29	1163	2126
Barwon Division of General Practice	52591	6382	7788	17	2	49	14	39	1073	1348
<b>NCAHS</b>										
Hastings Macleay Division of General Practice	102029	4631	21006	37	15	95	25	102	1074	1000
Mid North Coast Division of General Practice	131348	5604	22755	50	22	130	44	104	1010	1263
Northern Rivers Division of General Practice	165101	6029	26573	75	31	201	61	135	821	1223
Tweed Valley Division of General Practice	86797	2588	18856	33	8	102	29	80	851	1085
<b>GSAHS</b>										
South East NSW Division of General Practice	176606	4818	29164	58	19	192	47	111	920	1591
Riverina Division of General Practice	110212	3961	15842	35	11	85	27	84	1297	1312
Murrumbidgee Division of General Practice	61945	2775	9248	22	11	46	12	46	1347	1347
<b>GWAHS</b>										
NSW Central West Division of General Practice	174229	7845	25788	53	32	169	33	133	1031	1310
Dubbo Plains Division of General Practice	99321	10792	14783	34	17	85	25	79	1168	1257
NSW Outback Division of General Practice	15723	4310	1759	15	12	15	2	19	1048	828
Barrier Division of General Practice	22709	2079	3987	6	1	22	7	16	1032	1419
<b>NSW</b>	<b>6676852</b>	<b>145115</b>	<b>900296</b>	<b>2829</b>	<b>1295*</b>	<b>7352</b>	<b>2685<sup>A</sup></b>	<b>6253</b>	<b>908</b>	<b>1068</b>

Source: 2008 Primary Health Care Research &amp; Information Service

FWE = Fulltime Workload Equivalents not FTE

GWAHS includes part Mallee Division

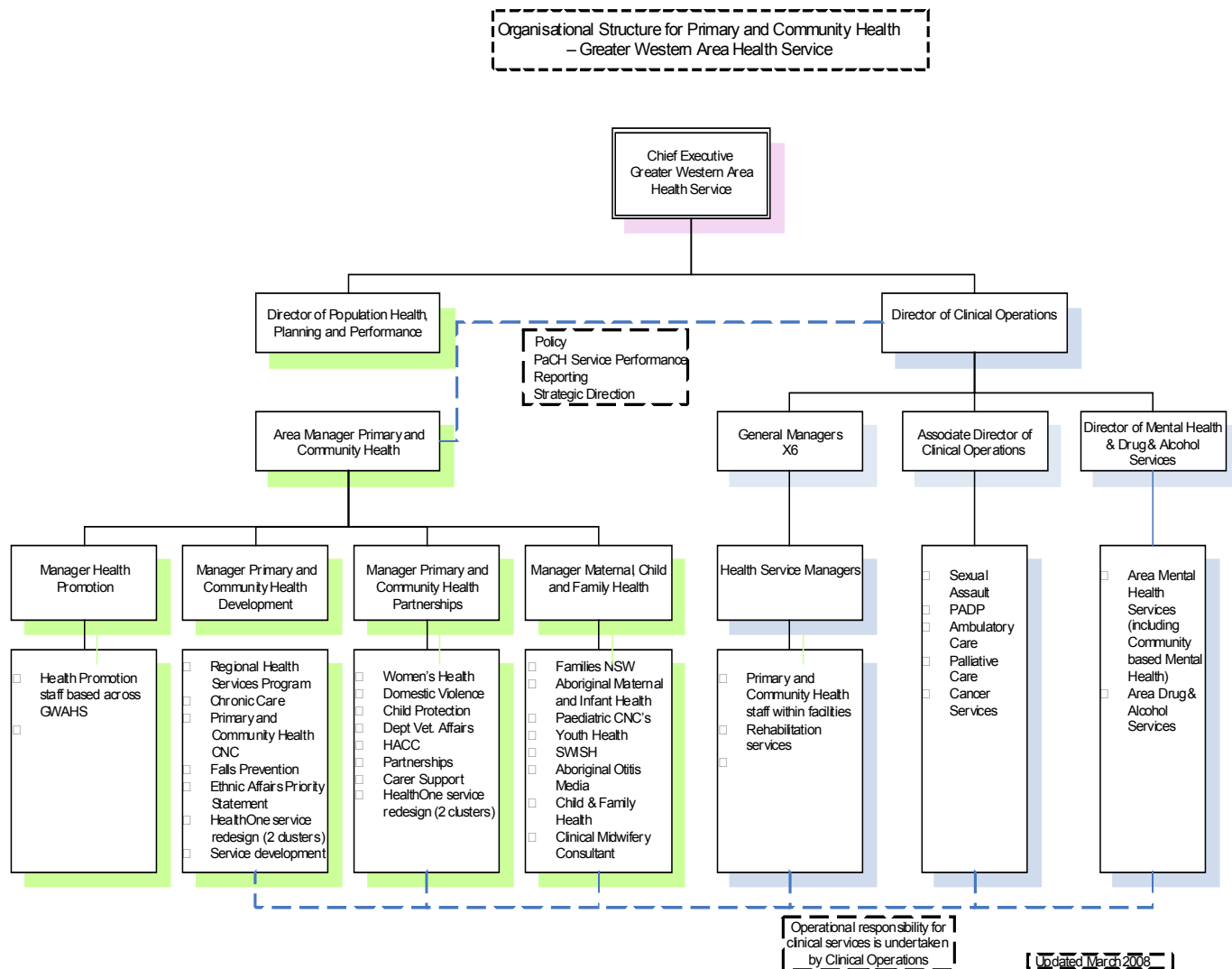
SSWAHS, SSWAHS and GWAHS all include part of Central West Division

## **Attachment 4**

### ***Area Health Service organisational charts***

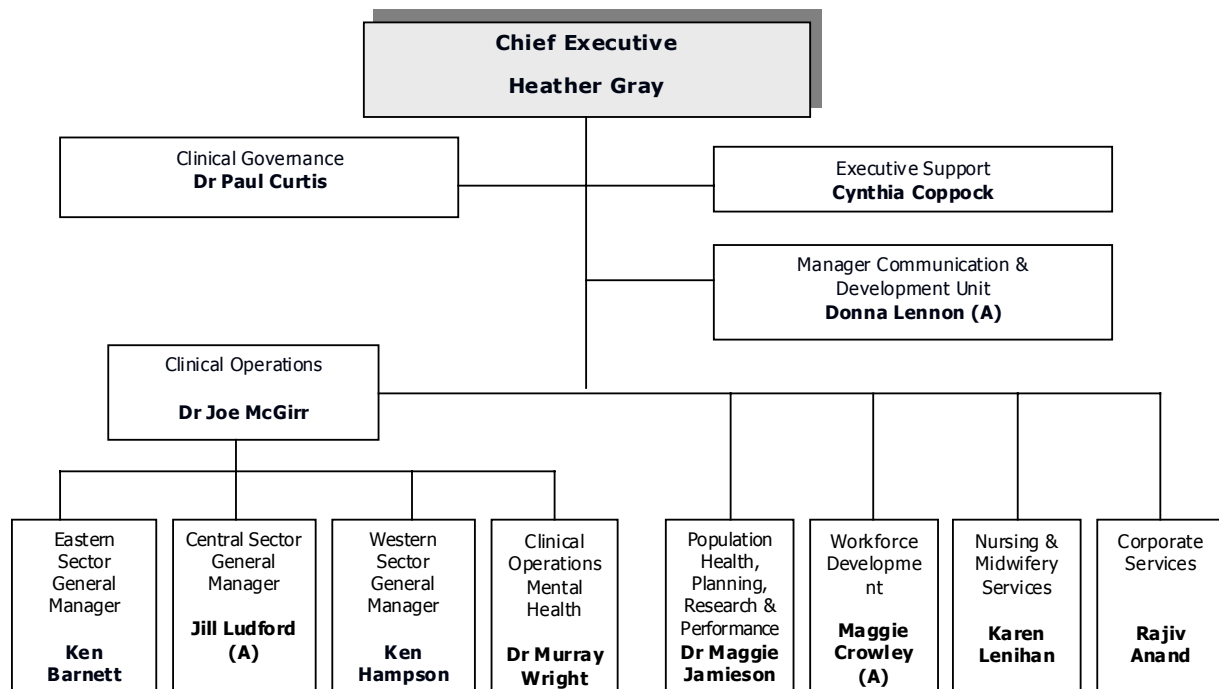
## Greater Western Area Health Service

**Figure 6** *Greater Western structure for Primary and Community Health*



## Greater Southern Area Health Service

**Figure 7** *Greater Southern Organisational Structure*

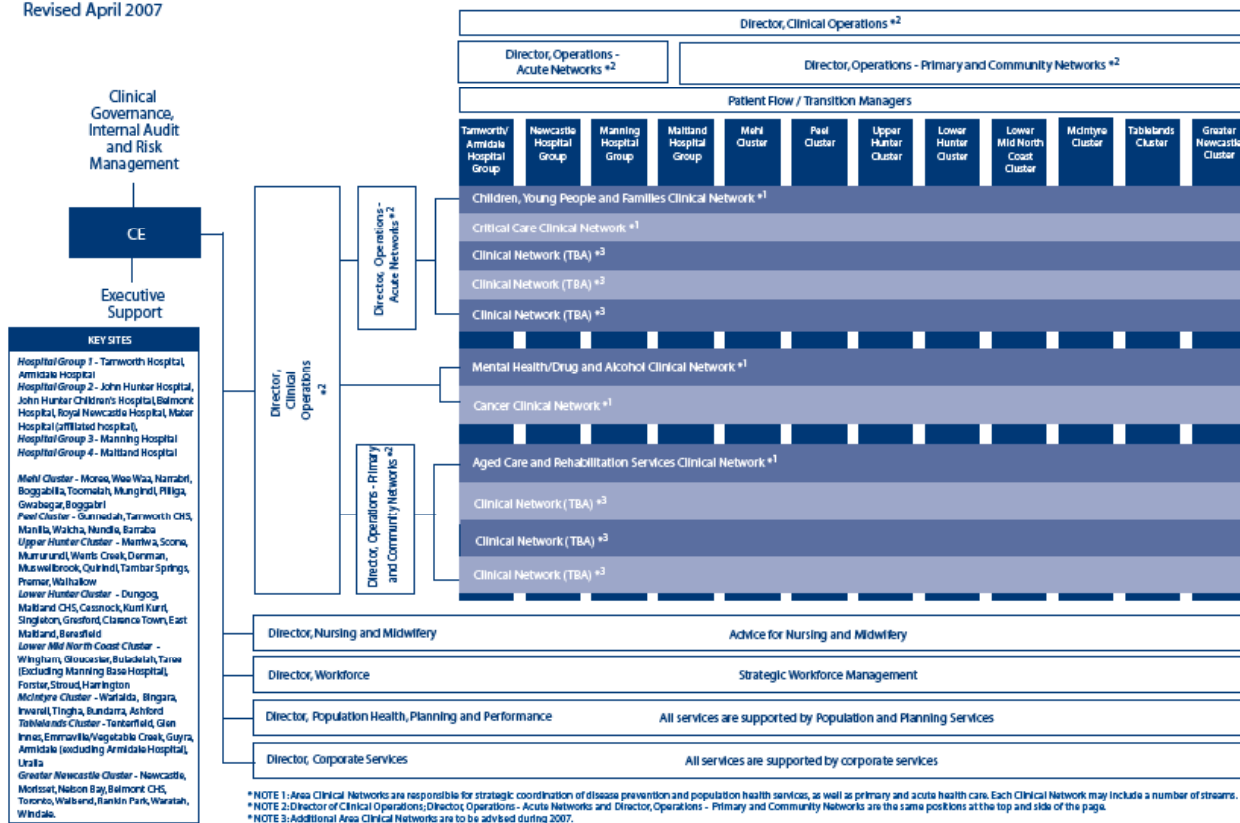


## Hunter New England Area Health Service

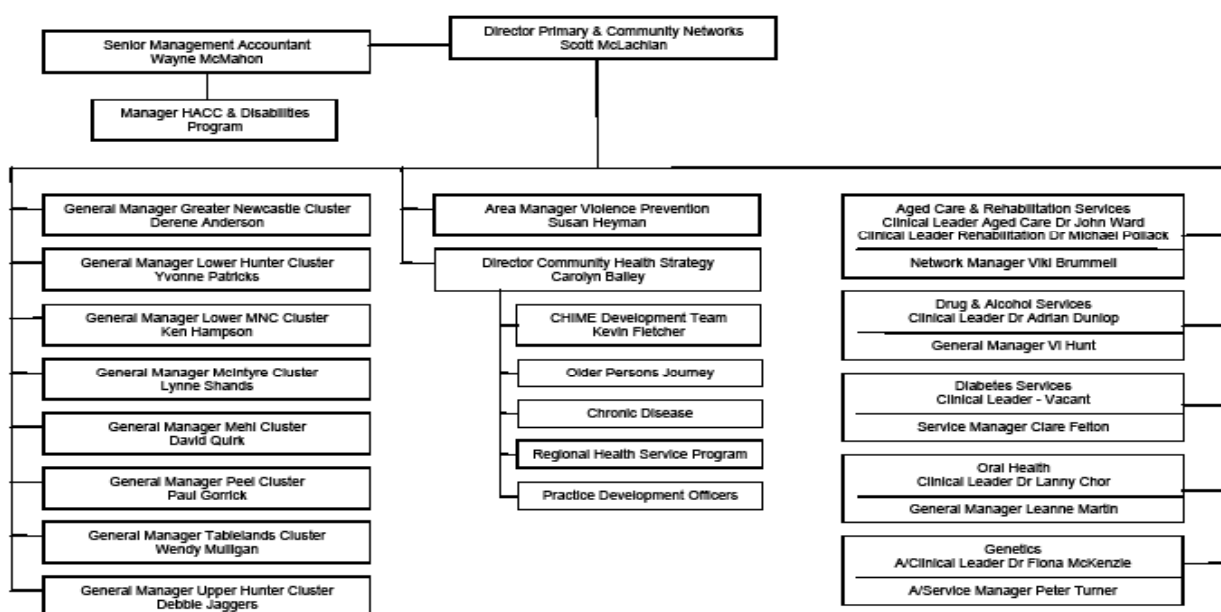
**Figure 8 Hunter New England Health clinical governance model**

### HUNTER NEW ENGLAND HEALTH CLINICAL OPERATIONS STRUCTURE

Revised April 2007

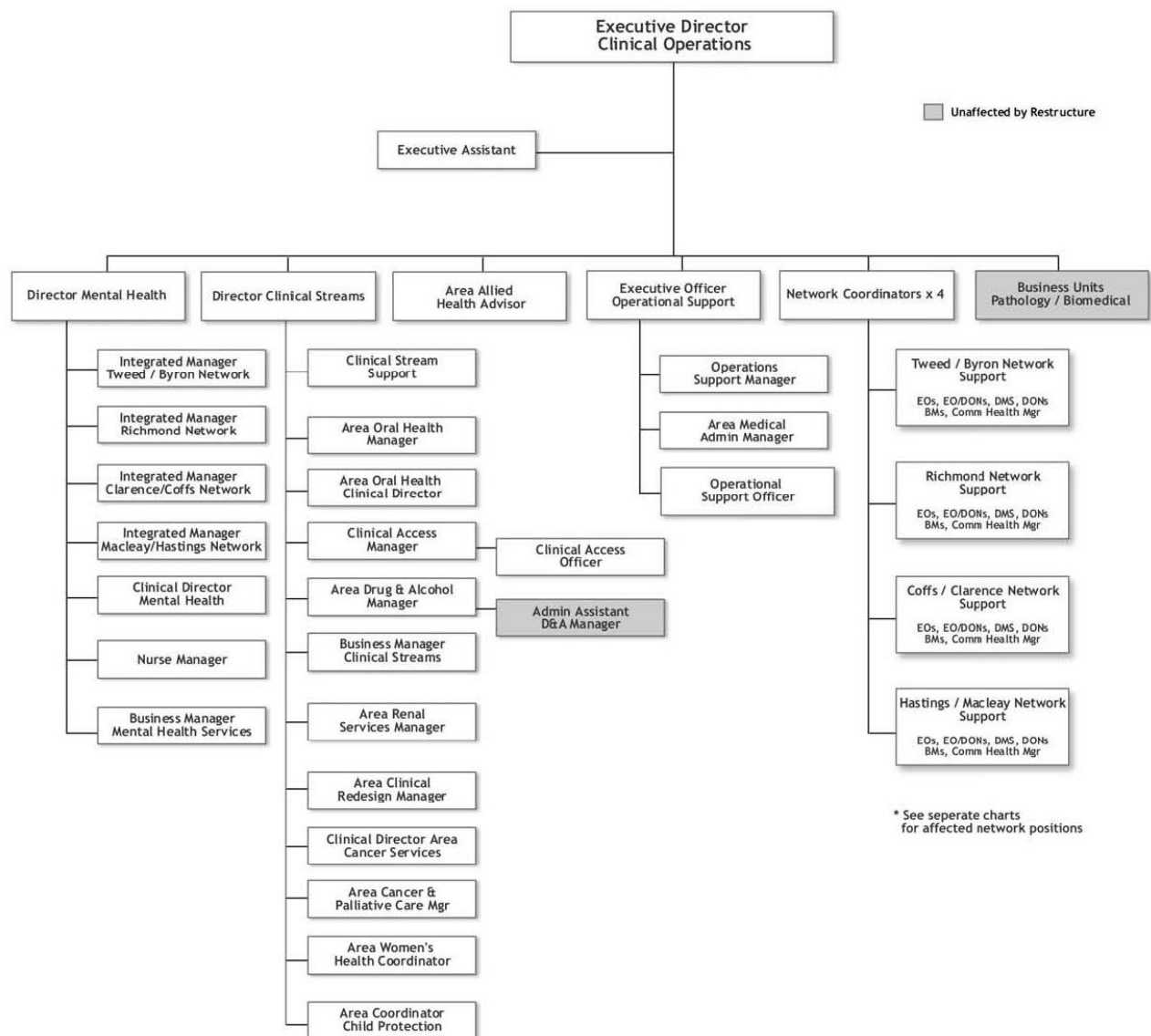


**Figure 9 Hunter New England Primary and Community Network Structure**



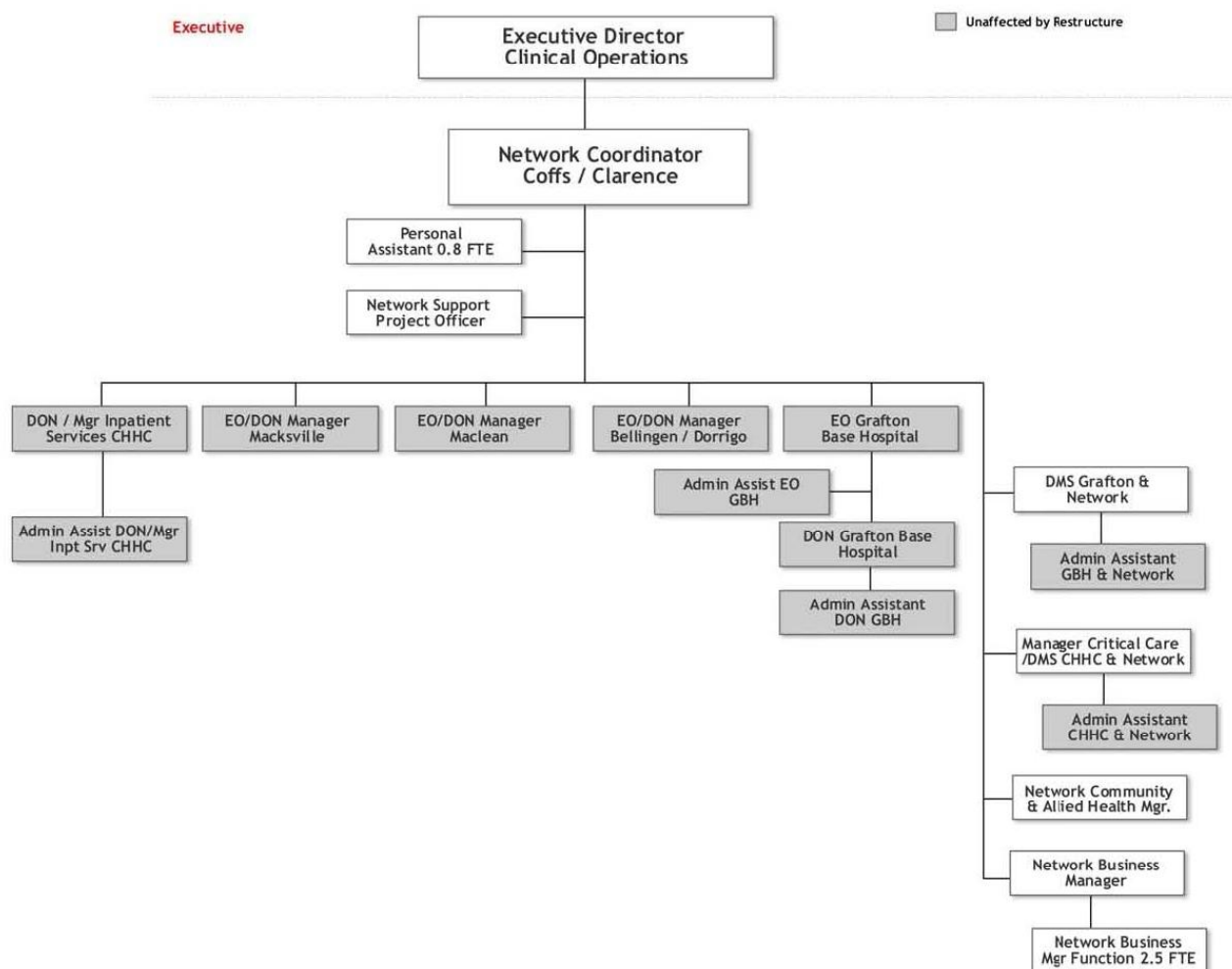
## North Coast Area Health Service

**Figure 10 North Coast Clinical Operations Structure**



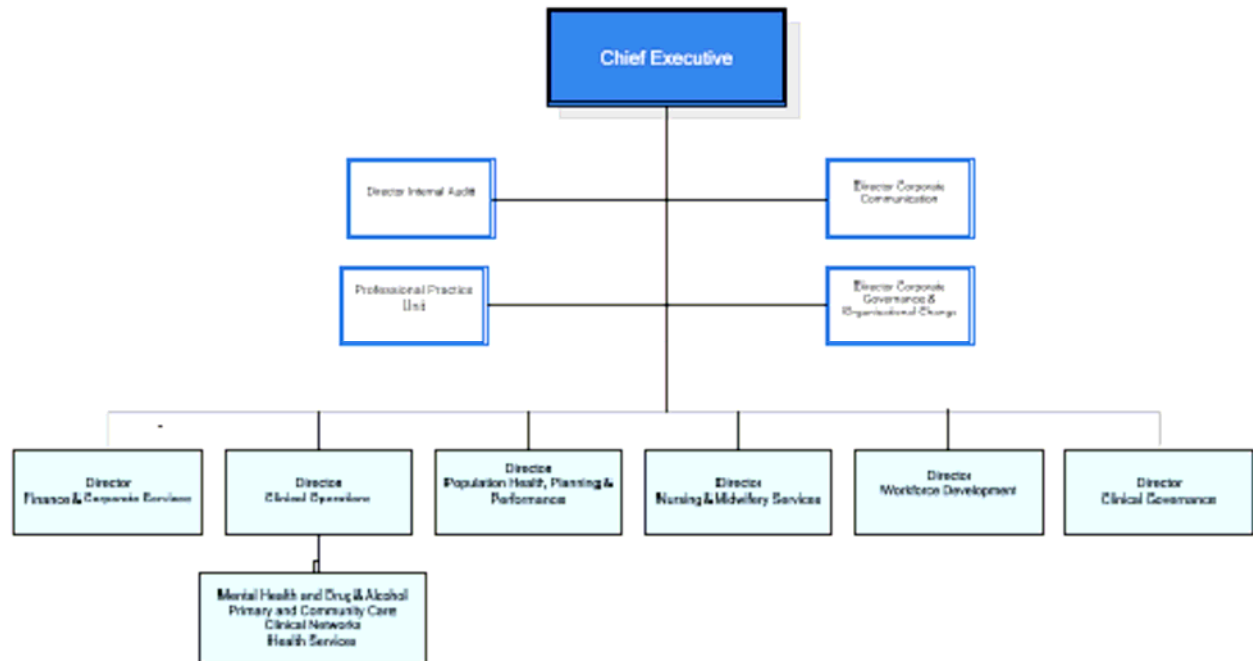
**Figure 11** An example of a network structure within NCAHS

Clinical Operations :: Coffs / Clarence Network

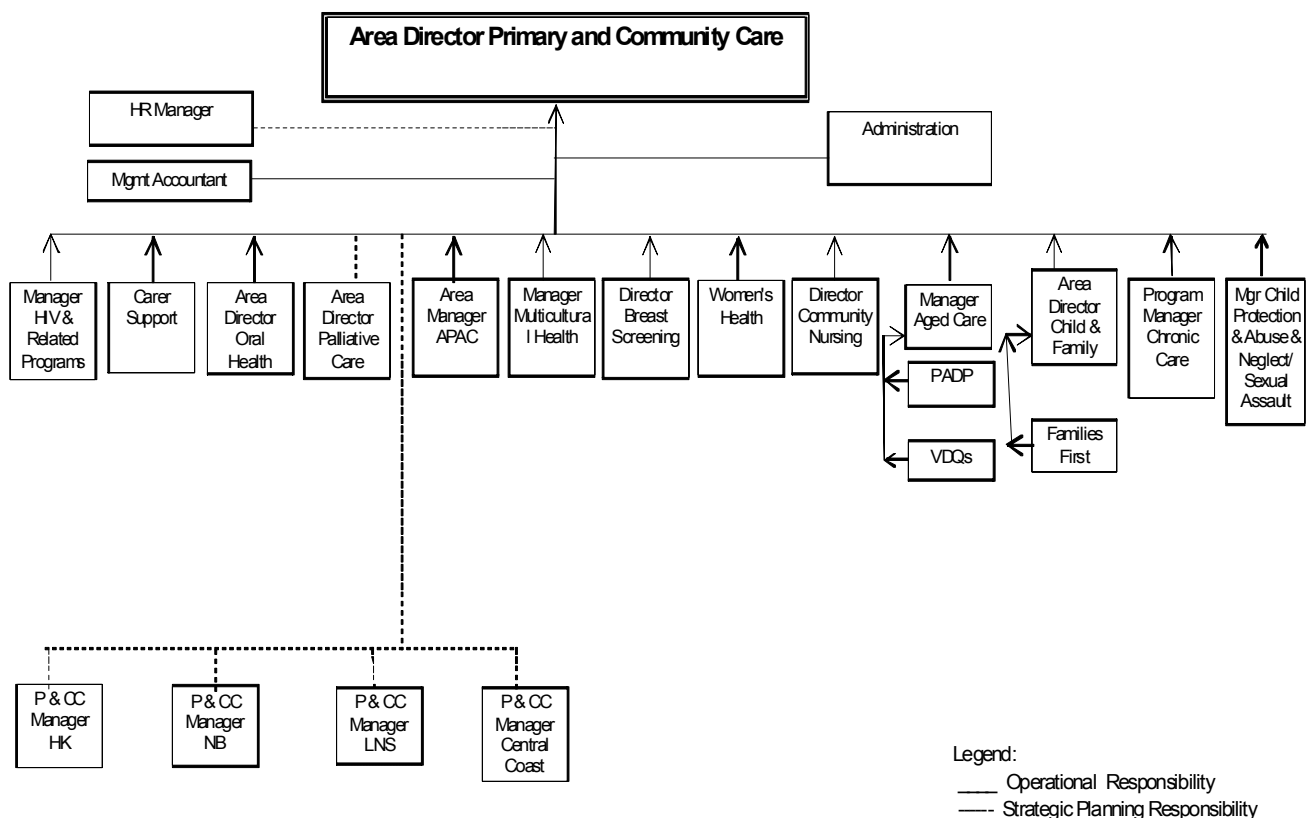


## North Sydney Central Coast Area Health Service

**Figure 12 North Sydney Central Coast Organisation Structure**

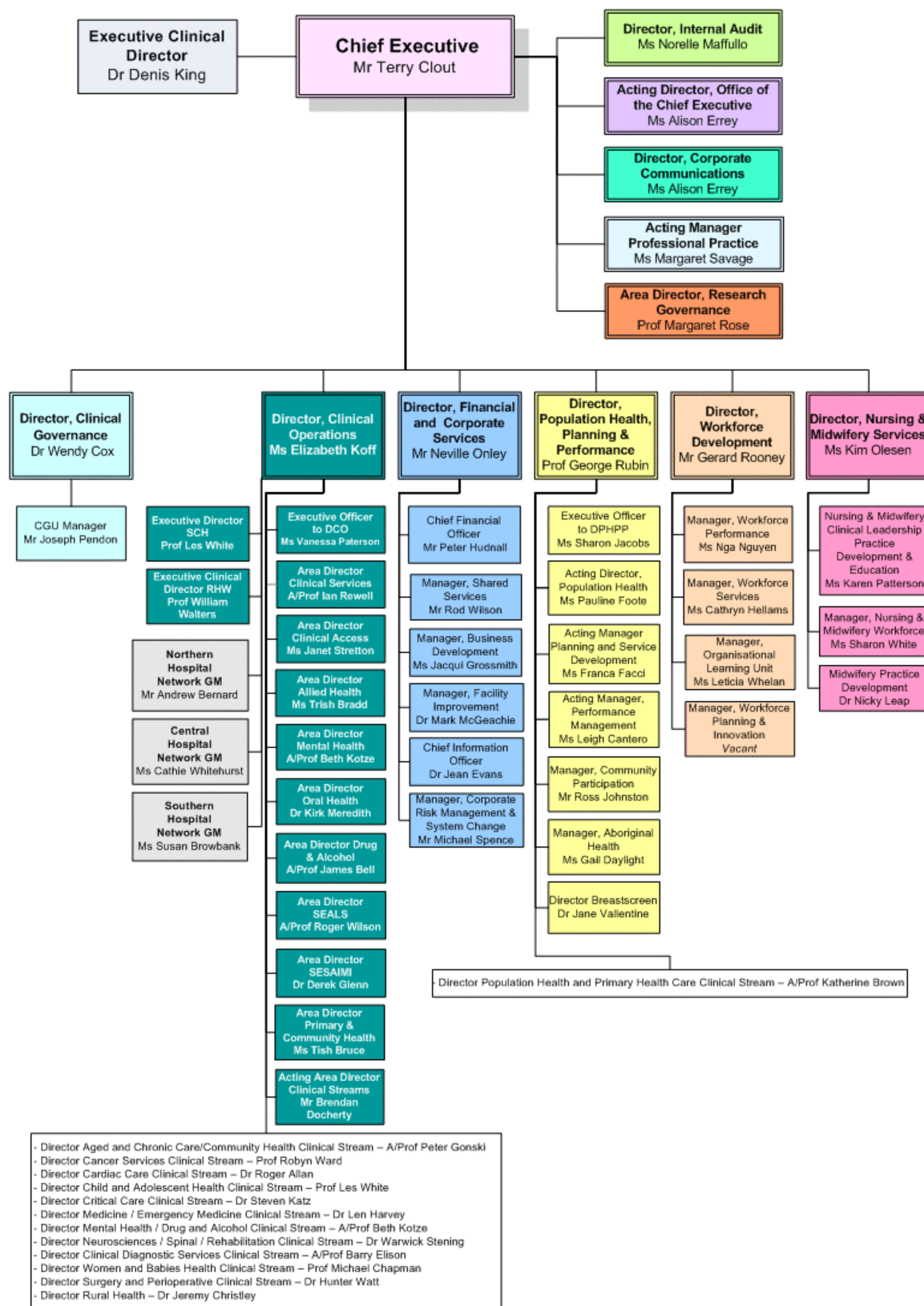


**Figure 13 Primary and Community Care Structure**

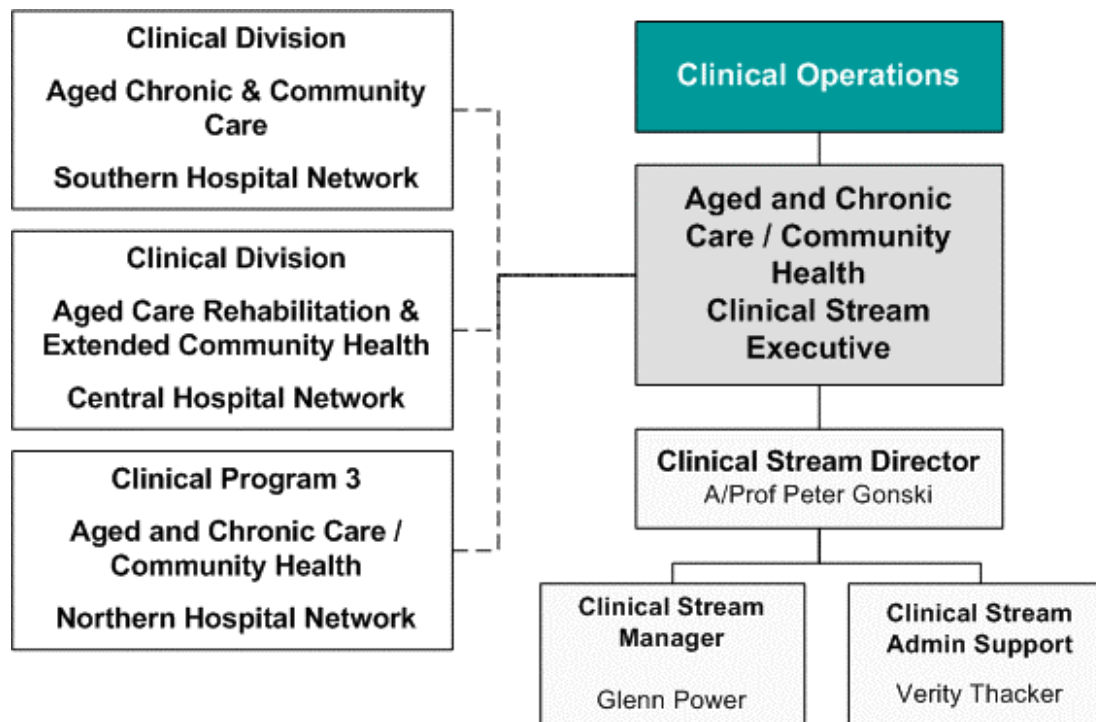


## South East Sydney Illawarra Area Health Service

**Figure 14 South East Sydney Illawarra Organisation Structure**

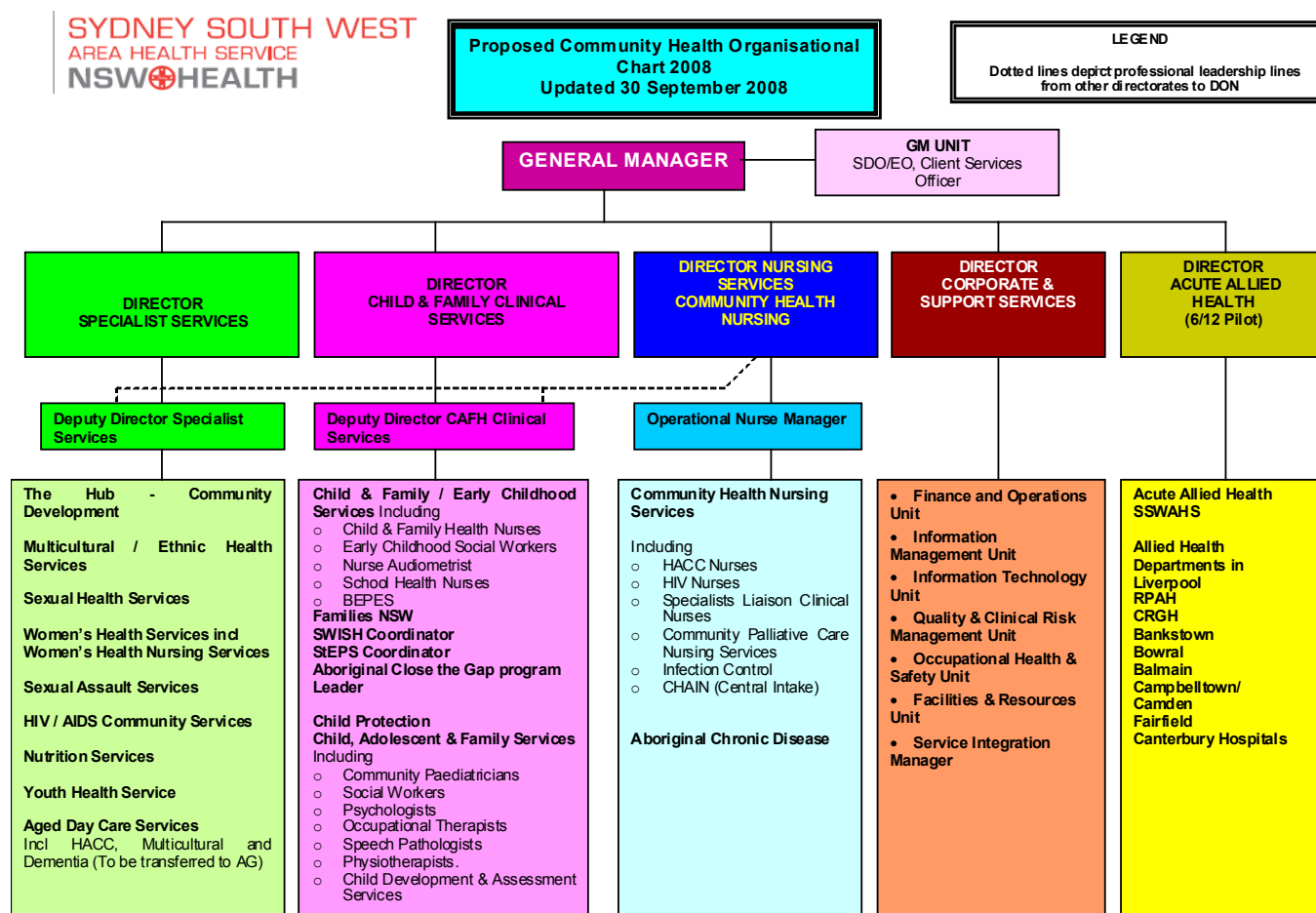


**Figure 15**     *South East Sydney Illawarra Clinical Operations Structure*



## Sydney South West Area Health Service

Figure 16 SSWAHS Community Health Organisation Structure

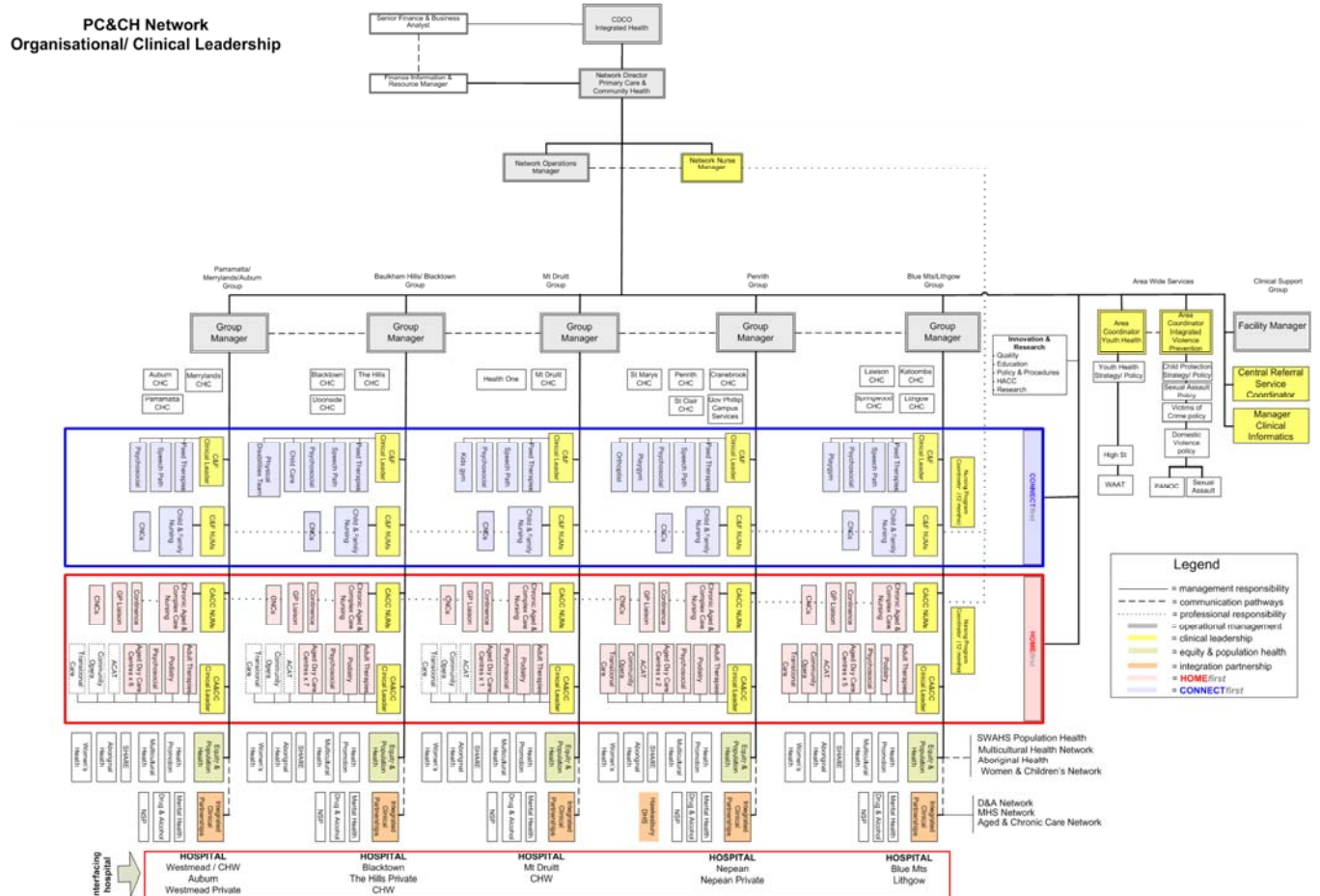


## Sydney West Area Health Service

**Figure 17 SWAHS Organisation Matrix**

CLINICAL NETWORKS*	WESTERN CLUSTER	CENTRAL CLUSTER	EASTERN CLUSTER	INTEGRATED HEALTH
Surgery & Anaesthetics Women's & Children's Health Cancer				
Chronic, Complex & Aged Care Rehab, Pharmacy & Allied Health Acute Interventional Medicine Teaching & Research				
Access & Patient Logistics Cardiac Services Pathology Imaging Oral Health				
Primary Care & Community Health Drug & Alcohol Mental Health				
Health facilities within each Cluster →	Portland Lithgow Blue Mtns Springwood Nepean Gov Phillip	Hawkesbury Mt Druiitt Blacktown	Westmead Auburn St Joseph's Lottie Stewart	Community Health Cumberland Pialla

**Figure 18 SWAHS Primary and Community Health Organisation Structure**



## Children's Hospital Westmead

Figure 19 Children's Hospital Westmead Organisation Structure

