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 oversights 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 a 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 Ku-ring-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 (SESIAHS) 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 SESIAHS 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 SESIAHS.

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 21st 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)

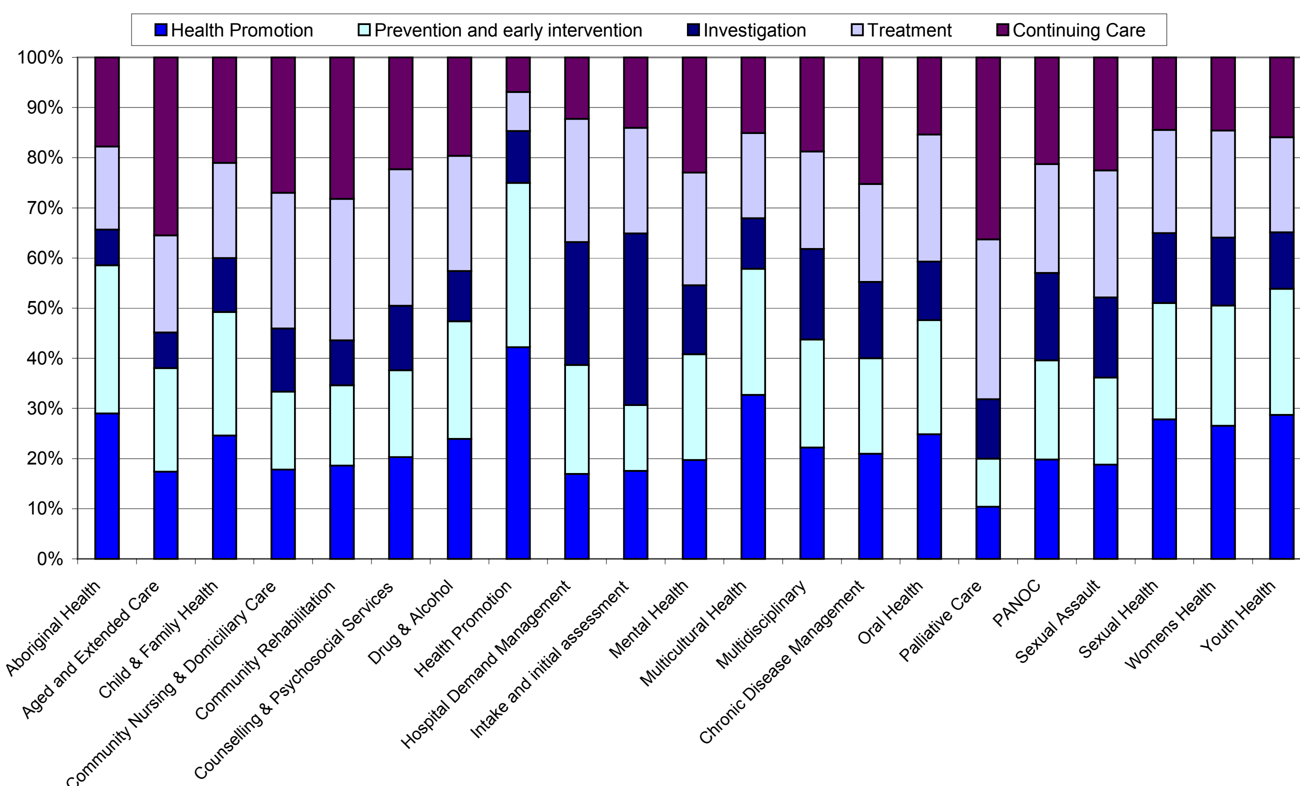

Table 3 Views from the on-line survey about where there should be more or less investment in the future

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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