LEGISLATIVE COUNCIL

PORTFOLIO COMMITTEES

# BUDGET ESTIMATES 2023-2024

## Responses to Questions taken on Notice

Portfolio Committee No. 2 – Health

**Health, Regional Health, the Illawarra and the South Coast**

Hearing: 22 February 2024

**Answers due by:** Wednesday, 20th March 2024

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TRANSCRIPT PAGE 2

The Hon. BRONNIE TAYLOR: Thank you very much, Minister and your team, for joining us here today. Minister, in relation to DLO secondments in your office, have you or your office ever requested specific public servants to fill DLO positions?

Mr RYAN PARK: Yes, I think I requested someone very early on from the ISLHD local health district. She stayed for only a few weeks. It was just to get me across not only the portfolio but also some of the challenges that we were having at ISLHD, particularly around ED pressure, that you would know, Bronnie. I requested her, yes.

The Hon. BRONNIE TAYLOR: Now that you have confirmed that, could you also confirm that the seconded DLO has not undertaken work that would contravene the Cabinet memorandum?

Mr RYAN PARK: Yes, certainly.

RESPONSE:

I am advised:

Ministry Liaison Officers (MLO) are and remain employees of the Ministry of Health. The role of the MLO is to provide the Minister's office with a readily accessible source of knowledge and skills regarding the operations of the government sector agency or agencies within the Minister's portfolio area/s.

It is expected that work undertaken by MLOs complies with Premier's Department Circular C2021-07 Department Liaison Officers.

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## TRANSCRIPT PAGE 9

The CHAIR: What percentage of the NSW Health nursing workforce was lost in 2022-23?

Mr RYAN PARK: Turnover: I might go to Mr Minns, if that's okay, because I don't want to mislead the Committee if the figure's slightly different to what I have in my head.

PHIL MINNS: Chair, the essential position with nurses, from memory — and I can get this clarified for you across the course of the day — is that our level of retention for nurses in midwifery is almost back to where it was ahead of COVID, so we did suffer more turnover, particularly after the Delta wave and the Omicron wave. That was after in the first year of actually having increased retention where people stayed to assist in the challenge, but I think the number is 1.1 per cent that we're below retention levels as at June 2019. Our retention rate for nurses and midwives is above 90 per cent, but I will get you an exact number. It's just buried in here somewhere.

## RESPONSE

I am advised:

The retention rate for nurses in NSW was 92.2% in June 2022, and rose by 0.3% to 92.5% in June 2023. This represents an improvement in the overall nursing retention rate over the 2022 to 2023 period.

Retention, in nursing, like other disciplines and other professions both inside and outside of NSW Health is impacted by staff who choose to take up other roles and opportunities, relocate, retire or for other personal reasons.

## TRANSCRIPT PAGE 9

The CHAIR: Thank you. I look forward to coming back to that this afternoon, Mr Minns, and I'll also come back to the safe staffing levels, which I'm not going to call nurse to patient ratios leader. Minister, I wanted to ask you some questions about Manning Base Hospital which, as you would know, is stuck between stage one and stage two of redevelopment and in really dire condition. When will stage two be completed?

Mr RYAN PARK: I'll refer to Rebecca Wark from Health Infrastructure in a moment, but Manning Base Hospital, as has to be brutally honest to this Committee and this Committee should be informed, is significantly challenged at the moment without capital spends across New South Wales. Infrastructure Australia recently indicated around about 13 per cent — let's just say 13 per cent — increases in capital, in cost escalations and things like that that. That has put pressure — no doubt people in local government would have been feeling this — on all of our regional and rural hospitals, including the Manning Base build. That's important just to give a context of what's happening.

In Manning Base, I actually spoke with the local member there yesterday. She also raised some concerns with me about Manning Base that the secretary and the deputy secretary are just working through at the moment. I don't have a date, but it is a hundred million investment in stage two. That'll be providing modern facilities and enhanced services and that's for the communities, obviously, of both Taree and Manning Valley — the region, broadly. Currently the project scope is being reviewed because of some of the cost escalations. I've been pretty up-front about that. That's a challenge. Every infrastructure delivery arm of every government or every local council or every private organisation is facing these cost escalations, according to Infrastructure Australia — not my figures — of at least 13 per cent. Some, we hear — Rebecca the CEO of HI will tell you — sometimes that's close to 30 per cent, and that's just what we're dealing with in a market. I don't have a date on that at the moment, but we are looking at that scope.

## RESPONSE:

I am advised:

The scope for the stage 2 redevelopment prioritises delivering modern facilities to support contemporary models of care, focusing on replacement of inpatient beds.

Bed numbers for the project will be confirmed as planning progresses.

## TRANSCRIPT PAGE 9 - 10

The CHAIR: But I'm also really concerned about the scope being reviewed because that means that you can get a redevelopment that doesn't actually meet clinical need on the ground. Manning Base Hospital, like Albury hospital, is routinely running at a bed deficit and is already really difficult to staff. Is there an update on bed capacity for stage two at Manning Base?

Mr RYAN PARK: I might refer to Rebecca, if you would like to give any further detail.

REBECCA WARK : Thanks Minister. I can't comment specifically around bed capacity and we can take that on notice, but I can confirm that we are working with the district around what their priorities are in relation to the scope.

## RESPONSE

I am advised:

The scope for the stage 2 redevelopment prioritises delivering modern facilities to support contemporary models of care, focusing on replacement of inpatient beds.

Bed numbers for the project will be confirmed as planning progresses.

## TRANSCRIPT PAGE 10

The CHAIR: Minister, you would have seen the recent media reporting on the unsanitary conditions at the hospital at the moment while it's still between the redevelopment stages. In response, Health Infrastructure NSW was reported to say that it would "continue to keep the community updated". What has actually been done to address those conditions in the short term?

Mr RYAN PARK: I will let HI talk about it, but we are obviously wanting to make sure that all of our hospitals are clean, safe and tidy — all of those things. That's a responsibility that I take very seriously and it is a responsibility that the secretary takes very seriously. Any of those issues, obviously, we are working on, on the ground through HI. But I understand from the local member that, in discussions I've had with her — and she has also written to me on a number of issues — she does have some concerns about Manning Base. The secretary and the deputy secretary, who look after systems and performance, are having a look at their data and having a look at what is happening there.

Not to make any insinuations or accusations, when people from the community, including local members, think that there is a concern at the local hospital, this is a part of the process to have a look at it. That's what we will do and we will no doubt do it at many, many other hospitals, as we have. No doubt when the former Government was in place, when people like myself and others — they were decent enough to have a look at whether there was an issue there that we needed to get to the bottom of. In a system like ours that is constantly changing and constantly under big influxes of people moving in and out of it, we have to constantly take seriously any concerns raised by people and have a look at it. Quality is something that is very important to us, as is safety. We will continue to do that. I'm not sure if you want to talk about the specifics and what work on the ground is happening.

REBECCA WARK: Minister, because we are still in the planning phase of that project, the specific cleaning around the hospital is an operational issue between the LHD and potentially HealthShare. It's not a matter for Health Infrastructure at this stage.

The CHAIR: If it's not a matter for Health Infrastructure, who can answer the question about what is being done in the short term to rectify the issues?

SUSAN PEARCE: Are you able to be more specific about what the issues are, Chair?

The CHAIR: Yes, there were some issues with dampness. Clinicians thought that there was a risk of mould. There have been photos shared of peeling paint and discolouration around vents in clinical areas of the hospital.

SUSAN PEARCE: I'm happy to take that up with the chief executive of the district and address those issues with her.

RESPONSE:

I am advised:

A full preventative maintenance schedule is in place at Manning Hospital. Any report of mould and damage is appropriately investigated – including consultation with independent occupational hygienists – and swiftly rectified.

The images shared in recent media about maintenance were not current. The issues were rectified immediately at the time after being raised by staff.

## TRANSCRIPT PAGE 12

The Hon. SUSAN CARTER: Deputy Secretary Willcox, if I could start with you perhaps. I note you wrote to LHDs on 20 October informing them of the revised funding envelope of $401 million for palliative care, down from $650 million and you attached a summary off the revised funding envelope for each local health district. I know you take your job very seriously; I know you are very responsible. Did you write that letter without the knowledge of your Minister?

DEBORAH WILLCOX: I couldn't specifically comment whether I briefed the Minister on that memo per se, but certainly in terms of how we worked with the Minister and with colleagues within the ministry and the LHDs to compile a profile for palliative care enhancements across the system, there are many conversations that are held in order to develop those plans. On that specific point I would have to take that on notice, but I would acknowledge that there were multiple conversations as we developed these profiles.

## RESPONSE

I am advised:

The role of the Ministry of Health includes allocating Ministerially approved budget expenditure to local health districts and specialty health networks for health service delivery. The Ministry of Health works with the Minister's Office and other stakeholders to ensure allocation of approved budgets.

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## TRANSCRIPT PAGE 15

The Hon. SUSAN CARTER: Perhaps I could explain my question. Did Sydney Children's Hospital and Hunter hospital expect to get more money for palliative care funding for children than what they will actually now be receiving?

DEBORAH WILLCOX: The next two years the pain and paediatric palliative care enhancements will increase for both the John Hunter Hospital and the Sydney Children's health network.

The Hon. SUSAN CARTER: Is that increase more or less than they had planned for, budgeted for, expected to be able to provide services to dying children?

DEBORAH WILLCOX: I would have to take the specifics of those two years and those allocations on notice, but my understanding is—

The Hon. SUSAN CARTER: Sorry, I'm confused. You're not aware of the detail of a 50 per cent cut to paediatric palliative care?

## RESPONSE

I am advised:

The NSW Government has committed $64 million over the next four years for paediatric palliative care, an increase of approximately 60 per cent, and includes paediatric palliative care services led by the Sydney Children's Hospital Network and Hunter New England Local Health District.

## TRANSCRIPT PAGE 16

The Hon. SUSAN CARTER: Will every single LHD and every single provider of children's palliative care across the board be receiving less money to assist the dying than they had planned for, they had budgeted for and they had expected would be delivered because it was there in the forward estimates?

Mr RYAN PARK: Ms Carter, every single LHD—I went through a couple and I can go through more, but I won't waste the Committee's time. That is not the approach that I take. People will know that that's not my approach. Every single LHD will receive more money this year and every other year for the forward estimates than they would have.

## RESPONSE

I am advised:

More than $1.7 billion over 4 years was provided for palliative care in the 2023-24 Budget. Funding for palliative care is 6.8% higher this year (2023-24) compared to 2022-23 and is set to increase again by 8% next year (2024-25). Funding for paediatric palliative care will increase to around $64 million over the next 4 years – or by around 60%.

As part of this significant investment by the NSW Government, every local health district, specialty health network and NSW Ambulance will receive a funding boost to ensure access to high quality end of life and palliative care across NSW.

In September 2023, annualised funding was provided to districts and further annualised enhancements will be provided in 2024-25 to 2026-27.

## TRANSCRIPT PAGE 17 - 18

DEBORAH WILLCOX: I think that is a good summary, Minister. I think it is important that we do note that all of our local health districts are able to provide emergency or life-threatening care after termination and have emergency referral pathways, and importantly for the community to be aware of the Pregnancy Choices Helpline, which can connect a woman with services nearest to them—and the appropriate services.

The CHAIR: The search program and the hotline were both in place before the election, although I acknowledge that they're important services. Are there public hospitals in New South Wales that have the technical capacity and staffing to be able to provide abortion services that aren't currently?

RYAN PARK: I'm sure there is but I don't want to mislead anybody.

DEBORAH WILLCOX: Yes would be the answer, Dr Cohn. Staff in our women's and reproductive services would have the skill and capability to provide that but, as you're aware, most early terminations are taken care of outside the acute hospital setting.

## RESPONSE

I am advised:

In 2023, the NSW Health Safe Access to Abortion Care Working Group was established to consider barriers and enablers required to improve safe and equitable access to abortion care in NSW.

Work to examine options to strengthen pathways and support equitable and safe access to abortion care is ongoing.

## TRANSCRIPT PAGE 18

The CHAIR: As you would know, there were recent TGA changes made at a Federal level that reduced red tape around medical abortion prescribing, which you mentioned in passing in your original response. As you would be aware, that can be prescribed by GPs up to nine weeks' gestation and is really critical to improving timely access, particularly in regional areas. Before the election last year Australian Clinicians for Choice wrote to all GPs and candidates calling for a centre of excellence that can provide training and support to the primary care centre. Is that something that's being investigated?

Mr RYAN PARK: No, not that I'm aware of. But training — there are probably multiple elements to this. Making sure that women know what is in their local communities or what might be more widely available to them is important to me and that's because it came up a number of times in the rural, regional and remote inquiry that that may not have been the case. Ms Willcox has, through the working group, tried to make that a focus — so not specifically around that particular issue, but the training of staff is something that we have an ongoing emphasis on in all parts in health and medical care across every district and across the entire system, to be quite honest. I'm not going to say that we are specifically working on that, but it is not something that I'm aware of. The Abortion Law Reform Act that you're very aware of, Chair, ensures that the termination of pregnancy is treated as a health issue. Also, from my knowledge — I'll just make sure this is the case from Ms Willcox — my understanding is that limits the prescribing of medical abortion medication to medical practitioners. But I just want to make —

DEBORAH WILLCOX: That's correct.

The CHAIR: Thank you, that is correct.

## RESPONSE

Answer provided on page 18 of the transcript.

## TRANSCRIPT PAGE 18

The CHAIR: Thank you, that is correct. I might come back to this topic this afternoon. On a different topic, in 2008 the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals — when Labor was last in Government — recommended the creation and maintenance of a centralised register of doctors available for locum work. What has been done to implement that recommendation?

Mr RYAN PARK: I can get some information — either one of my officials might have it — on that particular recommendation. But I'll tell you what we are doing with locums because, to be honest, it keeps me up at night. It's an issue that I know both former Ministers have raised during their time and no doubt continue to be concerned about. In some communities we're paying of the order of around $5,000 for locums. It's a challenge. We are looking at a piece of work — it is not yet ready to be presented to the Cabinet — around whether we can manage locums centrally, internally, through NSW Health. Mr Minns is leading that piece of work for me.

## RESPONSE

I am advised:

In 2008, Sydney West, Sydney South West, South Eastern Sydney, Illawarra, Northern Sydney and Central Coast Area Health Services (AHS) developed a project to create a NSW casual/locum medical pool. This was extended statewide in 2008.

The principles were:

- A NSW casual pool of non-specialist locums to be pre-credentialed and skills assessed to match against vacancies.
- Agreed locum rates across metro facilities with rates to be increased by rurality.
- A defined process for when facilities could engage locum agencies during crisis points when vacancies could not be filled from the centralised pool. The AHSs had to all agree to hold the agreement and not escalate outside of the set parameters.
- An incentive for doctors to book shifts early, and not cancel, by creating a points system with a certain number of points leading to attendance at a paid education day. The earlier a doctor booked a shift, the more points accrued.
- An IT system of centralised doctors in the pool and advertise shifts available that all area health services could use.

The project was unsuccessful for the following reasons:

- The project was initiated by 2 area health services and would have benefited from more planning, time, and resourcing for change management.
- Challenges attracting locums to the pool.
- Hospitals were not able or willing to hold back on escalation of shifts and rates offered to agencies, making the casual pool ineffective as locums could wait and get better rates through the agencies.

In 2009, NSW Health introduced the *Employment and Management of Locum Medical Officers by NSW Public Health Organisations* Policy which sets out the requirements for NSW public health organisations in the employment and management of non-specialist locum medical officers.

The policy includes a requirement that only agencies listed on the NSW Health Medical Locum Register are to be used to provide non-specialist locum medical officers.

To be placed on the register agencies must be accredited by a third-party auditor who confirms the agency meets the NSW Health standards and conditions under the policy to deliver services. The policy also contains a standard agreement that must be used by agencies to ensure they comply with pre-placements checks and recredentialling obligations.

To remain on the register, agencies are required to undergo a recertification audit every three years.

In 2012, NSW Health developed the *Remuneration Rates for non-specialist medical staff - short term/casual (locum)* policy to define short term remuneration rates and conditions by location across NSW. It has provision for an escalation of rates with Chief Executive approval to be reported to the Ministry. This policy is under review.

## TRANSCRIPT PAGE 19

The CHAIR: My beef is with the inefficiency of the use of private recruitment agencies, which I have personal experience with as well. How many different private agencies does NSW Health use for the recruitment of temporary health staff at the moment?

Mr RYAN PARK: I'd have to require Mr Minns. We can find that out.

PHIL MINNS: Take it on notice.

Mr RYAN PARK: I'll take that one on notice, just to make sure.

## RESPONSE

I am advised:

There are currently 59 locum agencies on the NSW Health Register of Medical Locum Agencies.

NSW Health policy requires that only agencies listed on the register are used by public health organisations to provide non-specialist locum medical officers.

To be placed on the register, agencies must be accredited by a third-party auditor who confirms the agency meets the NSW health standards and conditions to deliver services. The policy also contains a standard agreement that must be used by agencies to ensure they comply with pre-placement checks and credentialling obligations. To remain on the register, agencies are required to undergo a re-certification audit every 3 years.

Most of the agencies on the register are actively used by NSW Health organisations, noting local health districts engage such agencies directly at the local level. Agencies only receive payment if and when used.

## TRANSCRIPT PAGE 19

The CHAIR: It was in The Guardian last year that it was 59 different recruitment agencies that taxpayers are propping up the profit margins of. Can you tell me what the current cost is to NSW Health per year on the overhead fees to those recruitment agencies?

Mr RYAN PARK: No, but it would be substantial. I'll wait to see if Mr Minns, either now or over the course of the day, can provide that to the Committee. This is not to dilute the importance of the issue or the savings — I'm not saying that and that's why we're having a look at can this be done in house. And I'm not saying it can, but we are broadly having a look at the way in which we might do that. Locums and agency nurses, who are not locums but are part of a cohort of contracted labour, do represent less than 1 per cent of the total NSW Health full-time equivalent staff. They're important. I'm not saying that. If there are savings to be made, that's important; but we just have to put it in perspective as well.

I do know that I've got some advice but it's not the exact answer to the question. Non-specialist medical locum and agency nursing staff costs, including the fees, make up less than 2.5 per cent of the total payroll of NSW Health, but as for the specific budget allocated for the management, I'll just get Mr Minns to probably chase it down over the course of the day, if that's okay, or we'll take it on notice.

The CHAIR: Thank you very much. I look forward to getting that figure. In the meantime, has any work been done to centralise and harmonise the process for credentials and onboarding for NSW Health staff that move between LHDs for temporary work?

Mr RYAN PARK: Yes, I'm sure there has. This has actually been an issue that has come up multiple times and I know that the ministry working with the LHDs has significantly reduced that onboarding time. I'm going to say an average of 30 to 40 days, but I might be a little bit out there. What I knew when I came into this, one of the first questions or dialogues I had with my deputy secretaries and the secretary was around this perception that kept coming back to me that there was a substantial length of time for people to be onboarded and then often they would go to other positions, and we would lose that person or there were some challenges moving between the districts. I know Mr Minns and his team have done some work on that, so I just wanted to provide that context before we got down to the specifics.

RESPONSE

I am advised:

In 2022-23, NSW Health paid $37 million in agency fees for non-specialist medical locum recruitment. This represents about 0.22% of total payroll costs for NSW Health of around *$16.8 billion.

*Figure includes NSW Ministry of Health and Pillars.

## TRANSCRIPT PAGE 20

The CHAIR: Thank you. Let's come back to that at the next estimates. I'll come back to the Minister on the safe staffing levels taskforce. I understand that the safe staffing taskforce has reached an agreement for what's been referred to as phase one of implementation of safe staffing levels regarding NHPPD, wards, emergency departments and ICUs, and that this agreement controversially includes assistants in nursing in the numbers. My first question is: How long is the transition period that's being provided to services to recruit the additional staff required to achieve the safe staffing levels? When will they begin to be enforced?

Mr RYAN PARK: This reform is very significant in nature. I've said repeatedly, both in opposition and in government, that this will take time. It is arguably — some may have other views — in my opinion the most significant reform and change to the way in which public hospitals are staffed in many, many years. Between now and July 2027 we will commence the rollout of our safe staffing reform. We will continue with the taskforce. That includes representatives from the Nurses and Midwives' Association. The safe staffing reforms will be first implemented at Liverpool Hospital and Royal North Shore Hospital EDs. We will, as a taskforce, review the initial rollout and use it to inform the rollout to future sites, which we'll continue to oversee.

There are going to be challenges; there are going to be hiccups; there are going to be problems. I accept all of that, as does the Nurses and Midwives' Association. But in good faith we have reached an agreement. Last week the Nurses and Midwives' Association wrote to me saying that they've accepted our implementation plan and where we are at with that. But I say to them that I — as, no doubt, they — recognise that, given the scale and size of this reform, involving thousands more nurses, there are going to be some hiccups and challenges along the way. However, I firmly believe that this will be not a silver bullet but go a fair way towards improving health care within our hospitals. We had to start somewhere. We are starting in our EDs. We made that decision because we believe that the pressure is acutely on EDs and we needed to staff this reform. It will take place over the next four years.

The CHAIR: Minister, can I seek further clarification, specifically about the transition period? I really appreciate that there does need to be a transition period and that this wasn't going to be implemented overnight. Are you saying that just for phase one, some hospitals will be waiting until July 2027?

Mr RYAN PARK: No. We will be getting to them as quickly as possible. What I'm saying is that we may not have everything bedded down. We are rolling out

this reform over that period. We are obviously going to work as quickly as we can, but we are dealing with hundreds of hospitals. We are completely changing the way in which we staff. That will also involve a change in the way we escalate problems or disputes. All of these things are coming into play over the course of this term. I'm sure the Nurses and Midwives' Association would have liked to have all of this done in the space of six or 12 months.

The Hon. BRONNIE TAYLOR: You told them that.

Mr RYAN PARK: That's fine, but that's not possible. We said very clearly that this would be starting in our emergency departments and in our level 5s and 6s initially. We'll be doing this over the term of this Parliament. But, without a doubt, depending on how well it goes, there will no doubt be demands for the next government—hopefully that's ours—to continue the work of this reform.

The CHAIR: What's the anticipated cost of implementing phase one, as agreed?

Mr RYAN PARK: I'll probably have to come back to you on that, Chair. I might be able to get that sooner rather than later.

The CHAIR: Thank you. I'd be interested in that today, if someone has it.

Mr RYAN PARK: Sure.

The CHAIR: Or, if I can phrase the question a different way: How many additional nurses are required to meet the implementation of phase one?

## RESPONSE

I am advised:

In August 2023, the NSW Government entered a Memorandum of Understanding with the Nurses and Midwives' Association that committed 2,480 full-time equivalent roles towards minimum safe staffing levels.

The Safe Staffing Levels Taskforce is a key driver of that improvement. Representatives from NSW Health and the NSW Nurses and Midwives' Association, who serve on the taskforce, are progressing the implementation of safe staffing levels.

Local health districts and specialty health networks participating in the initial roll-out from early 2024 will shortly start operational preparation for implementation.

Liverpool and Royal North Shore hospitals are planned for the initial roll out.

The rollout is scheduled to occur until June 2027. The Safe Staffing Levels Taskforce will discuss, monitor and plan additional roll out schedules.

## TRANSCRIPT PAGE 22

The CHAIR: Minister, statistics show that Griffith-Murrumbidgee (West) has an unacceptable rate of suicide compared to the rest of the State. Will you support a much-needed acute inpatient mental health and drug and alcohol rehabilitation unit at the new Griffith Base Hospital redevelopment?

Mr RYAN PARK: It is an issue that the honourable member Helen Dalton has talked to me about. We haven't made that decision yet. I'm happy to get some advice on where that is up to. She has raised with me some significant concerns about the mental health of some of her communities in that area, so we are going to have a look at it. In fairness, given the length and breadth that she has raised this issue, I'm concerned, as I'm sure everyone is. I can't answer it directly but I'm happy to take it on notice just because I don't want to be misleading anyone, other than the fact that I understand it's an issue. She, in good faith, has raised it with me, and I think she has raised it with the Minister for Mental Health, the Hon. Rose Jackson, who is, as I understand, also looking at it, and we will have a look at what we are providing broadly in that community in terms of mental health support and what we can do in relation to that.

## RESPONSE

I am advised:

The Griffith Base Hospital redevelopment includes short-stay inpatient mental health beds for people experiencing low complexity mental health conditions. Patients requiring admission for alcohol and other drug withdrawal can also be admitted to Griffith Base Hospital and supported by the specialist community mental health, drug, and alcohol team. The redevelopment does not include an acute mental health inpatient unit.

Patients with complex conditions, or high clinical risk, will be transferred to the acute mental health inpatient unit in Wagga Wagga. Murrumbidgee Local Health District acute and recovery inpatient mental health services are in Wagga Wagga. Services are supported by a specialised multi-disciplinary workforce.

Supportive care to assist people to live well in the community, undertake their usual activities and keep their family and friend connections, is the best way to care for most people who experience mental health conditions.

A comprehensive specialist community mental health team is based in Griffith and the team provide interventions for children, adolescents, adults and older

people that is close to home, accessible, personalised, evidence-based and recovery-focused. There are no wait lists for NSW Health-funded services.

TRANSCRIPT PAGE 22

The CHAIR: While we're in that region, I understand that Finley hospital has been allocated $25 million for upgrades to the hospital, but I've been advised that that plan is for refurbishment and doesn't include any new services. The local community are concerned that essential facilities such as a rehab unit, mental health and renal health is an opportunity missed to include those. Given that Finley is an hour and a half from Albury and 2¼ hours to Wagga, will there be consideration of including those services at Finley hospital?

Mr RYAN PARK: I've been to Finley Hospital, and one of the people I met there, from my memory, actually won volunteer of the year at the Health awards. I don't want to say the name because I think I might have it wrong. But I did meet him and he raised the important work that they do. I will have a look at the specific budget around Finley and around the issues that you've raised and take it on notice, but it is important. That community provides an incredible service driven largely by a group of passionate volunteers, to be honest, who work very hard in conjunction with the LHD and staff in that area. They are great advocates for their hospital. I'll have a look at the specifics. If I can't get it to you today, I'll take it on notice and I'll do my best to try and get it ASAP.

## RESPONSE

I am advised:

Murrumbidgee Local Health District will work to implement the models of care outlined in the Finley Clinical Services Plan in line with infrastructure upgrades, community needs and workforce planning.

The Finley Hospital redevelopment funding does not support construction of a complete new build. However, upgrades are planned to be operationally flexible to support the delivery of any future additional health services. The project scope delivers a mix of new and refurbished areas.

### Mental health services

Mental health and drug and alcohol services were highlighted in community consultations as a priority.

Virtual care is used for patients presenting to the hospital with acute mental illness, linking patients and staff to specialist mental health emergency staff for patient assessments and recommendations for management and treatment. The redevelopment will include a dedicated and purpose-designed

room for people presenting with mental illness to receive assessment and care in the emergency department.

Finley Health Service is not declared or gazetted for overnight mental health inpatient stays. The District's Mental Health Emergency Care Service is available at Finley Hospital 24/7 for specialist mental health assessment by virtual care. If a mental health admission is required patients are transferred to an appropriate facility.

Community mental health and drug and alcohol services are available in Finley with clinicians providing an onsite outreach service including home visits for adults, older persons, adolescents, and children. Care for higher prevalence, lower acuity mental health conditions are provided through a range of services commissioned by the Primary Health Network. Other programs provided by the District include Farm Gate, MyStep to Mental Wellbeing, Safeguards Program and Suicide Prevention Services.

### Rehabilitation services

A new Physiotherapy Optimising Care Model at Finley Hospital is in development to deliver support services closer to home using suitable clinical spaces available in the facility.

Access to allied health staff will be networked with sites throughout the Finley cluster and aims to optimise post-operative outcomes for consumers, increase accessibility to cardiac and pulmonary rehabilitation, improve inpatient functionality following extended hospital stays and support movement disorders.

### Renal dialysis

A renal unit was not recommended in the Finley Clinical Services plan. Renal services providing haemodialysis are available in Deniliquin, 42km from Finley, and includes
a 9-chair renal unit.

The service has capacity for additional growth to cater for increased demand and a multidisciplinary team to support people with chronic kidney disease in the community. A bimonthly nephrology clinic is available in Deniliquin in partnership with Royal Melbourne Hospital.

Renal team staff provide outreach services, including the Finley area, for Home Dialysis patients.

## TRANSCRIPT PAGE 27

The Hon. SUSAN CARTER: Have the local health districts been formally advised of what you have in the forward estimates for those past two years?

Mr RYAN PARK: I'll stand corrected, but it's our budget. There'll be movements and discussions between the ministry —

The Hon. BRONNIE TAYLOR: Perhaps you would like to take that on notice, Minister Park?

The Hon. SUSAN CARTER: Can I draw your attention to a memo that was written by Tish Bruce to Ms Willcox where she attaches those figures and notes that, "Increased funding above 24-25 level has not yet been advised to LHDs for both the 25-26 and 26-27 years." Why would LHDs, who need to plan, not be given sufficient notice of what their funding envelope was going to be?

Mr RYAN PARK: They do get sufficient notice. What do you mean? They know what they're doing within a period of time.

## RESPONSE

I am advised:

In the 2023-24 State Budget, the NSW Government confirm its ongoing investment to ensure people across NSW have access to high quality end of life and palliative care they need.

In October 2023, the NSW Ministry of Health confirmed the latest allocation under the World Class End of Life Care commitment. The Ministry advised local health districts and speciality health networks that allocations in 2025-26 and 2026-27 under the World Class End of Life Care commitment will be communicated with upcoming Service Agreements.

The Ministry will continue working closely with districts and networks to support planning and implementation of funding allocations.

## TRANSCRIPT PAGE 29

The CHAIR: —you quoted infection prevention and control policies which include the following. It stated, "Staff caring for or working in areas where there are vulnerable patients should consider using masks routinely when COVID-19 transmission increases." We know that COVID-19 transmission increased significantly over the summer holiday period. Do you think it's sufficient that staff need to consider using masks, or are we at a point where COVID transmission has increased enough that staff should be wearing masks in clinical areas with vulnerable patients?

Mr RYAN PARK: I will refer to my colleague Dr Chant on this matter, but I will say a few opening comments. We have seen increases in the order of moderate to high, I suppose, in terms of COVID transmission at the moment. We are sending all of those messages, and all of that data gets provided to local health districts around the importance of looking after vulnerable patients and vulnerable members of the community who may come into that hospital. I will ask Dr Chant to elaborate, but I don't want the Committee to at all think in any way, shape or form that we are not taking the challenge of COVID seriously. But we are, as a community, learning to live with it. That includes in our hospital and vulnerable settings. But we do have measures in place to—what I would call—protect, as much as possible, the most vulnerable people in our community. They're often people who are elderly or in our hospitals.

KERRY CHANT: The Clinical Excellence Commission deals with the infection prevention and control recommendations for the hospital, which gives an ability for the hospitals to tailor—as you've described there—what might happen around a vulnerable patient or, particularly for services that service and cater for vulnerable people, a much higher level of stringency in terms of the recommendations. I'm happy to take on those examples, if you would like to provide them, just to feed back and investigate the infection control and prevention strategies in place. I think it's really important because, as you know, even in a surgical or day patient setting there may be patients who are vulnerable. I'm very happy to take that on board.

RESPONSE:

I am advised:

The Clinical Excellence Commission, as the lead agency for infection prevention and control and healthcare associated infection, provides comprehensive policies, guidelines, and resources to support NSW Health.

Implementation of infection prevention and control is supported by globally acceptable practices and frameworks adopting standard and transmission-based precautions. Standard precautions are applied equally to all patients, assessing risk of infection transmission and acquisition. Additional guidance for vulnerable groups is provided in the IPC Practice Handbook, including enhanced strategies and protective precautions.

NSW Health has moved from an emergency (pandemic) response to managing COVID-19 in keeping with the management of all other transmissible (or contagious) infections.

NSW Health organisations are recommended to implement the NSW Infection Prevention and Control (IPAC) response and escalation framework as part of their ongoing management of COVID-19 and other acute respiratory infections. The foundational level of the framework provides core infection prevention and control measures for protecting patients, staff and visitors and for preventing and managing acute respiratory infections including COVID-19.

Foundational level underpins all the alert levels used during the pandemic. Staff are no longer required to universally wear masks in all clinical and patient facing areas and have moved to a risk assessment application. IPAC strategies are well embedded in our health system, shifting away from the mandatory and universal application (emergency response) to a risk management approach.

Masks are required in line with the following:

- As standard precautions when risk of exposure to blood and body substances is anticipated.
- As transmission-based precautions.
- Patients who come to hospital with an acute respiratory infection, or suspected or confirmed COVID-19, are still required to be isolated and wear masks.

- P2/N95 respirators are to be worn by staff when caring for patients with COVID-19 or other airborne pathogens, and surgical masks when caring for patients with other acute respiratory infections as dictated by known modes of transmission.
- Patients considered vulnerable are provided with additional information on risk mitigation strategies.
- Health workers noncompliant (including exemptions) with influenza or COVID-19 vaccination, are required to wear a surgical mask as a minimum while in the health facility (clinical and non-clinical areas).
- Additional protection required for vulnerable patients: (examples include but not limited to immune compromised, immunodeficiency, transplant.

## TRANSCRIPT PAGE 33

The Hon. BRONNIE TAYLOR: I'm sure you do, Minister, but I'm sure you know what I mean. It was not meant to be demeaning to Minister Jackson. I want to know whether your Government is committed to the new Westmead mental health facility?

Mr RYAN PARK: I'll get some advice on that. I'll take some advice in relation to that. Ms Willcox looks after the mental health branch of NSW Health. They largely interface between Minister Jackson and led by Ms Willcox.

## RESPONSE:

I am advised:

The NSW Government has committed $460 million to the new Integrated Mental Health Complex at Westmead Health Precinct. Early works are under way and the main works are out to tender for a contractor. Construction on the new building is expected to begin in late 2024.

## TRANSCRIPT PAGE 34

The Hon. BRONNIE TAYLOR: I'm sure you agree, but I want to ask you, Minister Park — and please correct me if I'm wrong — but I recall during the election campaign that the announcement was generally, overall, for nursing students to be able to take this subsidy and then they had to commit to five years in the New South Wales health system. But when I go onto the NSW Health website now and I look — and, actually, a nursing student sent this to me, Minister Park, which I am very happy for as the shadow for regional, and obviously that is a lot of my focus. But now the subsidy is only eligible for those in the MM3 to MM7 locations. Have you changed that from your election commitment to this?

Mr RYAN PARK: I would have to have a look at that correspondence around that specific issue.

The Hon. BRONNIE TAYLOR: But, Minister Park, do you not agree that your election commitment was to provide those subsidies to nursing students that would commit to NSW Health for five years?

Mr RYAN PARK: Well, yes. But —

## RESPONSE

I am advised:

Please refer to comments from Mr Phil Minns on page 45 of the transcript.

The Tertiary Health Study Subsidy Program is now open to all students studying a tertiary health program that will lead to employment with NSW Health in an eligible workforce group. Previous requirements for nursing, medicine, and paramedicine graduates to work in a Modified Monash Model (MM) 3 – 7 locations are no longer applicable.

All students studying in these programs are eligible to apply, where preference will be given to:

- commencing students who are willing to work with NSW Health in a regional or rural location.
- graduating students who have accepted employment with NSW Health in a regional or rural location.

Eligibility criteria and eligible workforce groups will be reviewed yearly for the following year.

This information has been updated on the NSW Health website.

## TRANSCRIPT PAGE 38

Ms CATE FAEHRMANN: I want to hand you a piece of paper. If I can give it to the secretariat and I will wait while it is handed to you. What I am handing you is a NSW Health alert for a particular drug.

Mr RYAN PARK: Yes, I read these each time. Dr Chant's office communicates with me about this.

Ms CATE FAEHRMANN: So the one before you—

Mr RYAN PARK: Yes, I think this is the one with a bull logo, from memory.

Ms CATE FAEHRMANN: Yes.

Mr RYAN PARK: Yes, it is the one with the bull logo.

Ms CATE FAEHRMANN: What happens with these health alerts—

Mr RYAN PARK: Sorry, Ms Faehrmann, is this the one that was issued back in January, from memory,

Ms CATE FAEHRMANN: Yes. What happens with these health alerts when they're issued?

Mr RYAN PARK: Dr Chant is the person—

KERRY CHANT: The Ministry has a process of engaging with a range of experts, including NUAA and other committee organisations, in an expert panel to assess the significance of any of the detections and to determine the appropriate course of action. There are two arms—

Ms CATE FAEHRMANN: That's fine. You know how it goes with this. I will ask you this afternoon. I am aware, but thank you.

KERRY CHANT: Sorry, Ms Faehrmann.

Ms CATE FAEHRMANN: Thank you, Dr Chant, I know you were answering the question. Minister, this was published on 29 January, which was a Monday. The reason it was published was because these pills were in fact consumed by people at least one dance music festival that weekend, on the Saturday night. Are you aware of what happened at that festival?

Mr RYAN PARK: Yes, I'm aware there were some issues which resulted in the identification of this. I'd need to go back and check.

RESPONSE

I am advised:

That on the night of Saturday 27 January 2024, when the patients presented at the festival's onsite medical service a clinical toxicologist from the NSW Health Poisons Information Centre was contacted to advise on clinical management. A Medical Advisor from the NSW Ministry of Health was contacted to ensure that all relevant stakeholders were aware of the situation.

DanceWize NSW peer educators were asked to pass on a description of tablet to event patrons and explain that people were becoming ill from using it. In addition, stakeholders agreed to alert patrons via announcements from both stages.

While the patients were being cared for in hospital a screening test was run on one of the tablets. The results were inconclusive.

Early in the morning of Sunday 28 January all NSW Poisons Information Centre staff and toxicology networks were notified of the cases. The NSW Ministry of Health Medical Advisor alerted NSW Health Pathology, Forensic Analytical & Science Service about the need to expedite confirmatory testing of samples.

On Monday 29 January, samples were urgently transported for confirmatory analysis to ensure that accurate and specific messages could be conveyed to the public. Once the results were provided a Standing Panel of experts was consulted to advise on the scale and targeting of the drug alert. Subsequently, the alert was issued along with social media activity and radio interviews. This was accompanied with direct distribution to service providers with reach to community and clinical networks to ensure maximum awareness.

## TRANSCRIPT PAGE 45

The Hon. BRONNIE TAYLOR: How can you try to correct something? It's either correct or it's not correct. But I'll watch and I'll tell the students to watch the website. Mr Minns, when you say that there was $76 million in health study subsidies for this program for nursing students, correct?

PHIL MINNS: The new study scholarships?

The Hon. BRONNIE TAYLOR: Yes.

PHIL MINNS: I've got a global number of $129.1 million.

The Hon. BRONNIE TAYLOR: Okay. Just explain to me how many students there were this year. How many students are there that are eligible to apply for this?

PHIL MINNS: I'd have to take that on notice.

The Hon. BRONNIE TAYLOR: Please take that on notice and provide it to me. What I would also like to know, Mr Minns, because you are much better at mathematics than I am, is that of those students that are eligible to take up this program, what the cost of that would be compared to the cost allocated. Does that make sense?

PHIL MINNS: I understand you're asking, if everybody who was studying in these disciplines in New South Wales was to have a scholarship, what would the value of that be.

The Hon. BRONNIE TAYLOR: Yes, and I would like to have a value and a percentage, if I may be so indulgent.

PHIL MINNS: On notice, obviously.

The Hon. BRONNIE TAYLOR: Understood. That's fine, Mr Minns.

PHIL MINNS: It's not always the case that universities share all of their information about enrolments with us.

The Hon. BRONNIE TAYLOR: Even if it's a ballpark figure, Mr Minns, I'd really appreciate that, but as accurate as it could be would be really, really good.

RESPONSE:

I am advised:

NSW Health does not have access to the overall student numbers of tertiary educational institutions.

The Tertiary Health Study Subsidy Program will support up to 12,000 healthcare students with subsidies over the next 5 years. The program aims to create a workforce pipeline by attracting students to study a health profession of need in the NSW public health system. Each year (2024, 2025, and 2026), 2,000 subsidies will be awarded to students who start their study in an eligible workforce group, while another 2,000 subsidies will be awarded to students who have completed their study and secured employment in an eligible NSW Health workforce group.

## TRANSCRIPT PAGE 47 - 48

The Hon. BRONNIE TAYLOR: Mr Morgan, can I just add one more in? In regard to the Wagga Ambulance station — I'm not sure if this should be directed to you or to the secretary — the Minister announced in October last year that Wagga city council would be returned the $610,000 they paid for the old ambulance station. Maybe this is Health Infrastructure. I want to know where in the budget the funds were found for the refund.

ALFA D'AMATO: We have identified some savings.

The Hon. BRONNIE TAYLOR: We gave back $610,000. Sorry, the Government received that. I want to know where in the budget was that new money that was found to repay, or was that needed to be found internally?

ALFA D'AMATO: As I say, it was just savings that we identified internally. The Hon.

BRONNIE TAYLOR: Sorry?

ALFA D'AMATO: We identified some savings internally.

The Hon. BRONNIE TAYLOR: Would you be able to confirm if those savings that were found internally were found from other projects in Wagga, or was that just generally across the board?

ALFA D'AMATO: I need to double-check that.

The Hon. BRONNIE TAYLOR: Would you mind taking that on notice, Mr D'Amato?

ALFA D'AMATO: Sure.

The Hon. BRONNIE TAYLOR: I want to know, too, when you take that on notice, if any Health Infrastructure projects were cut or reduced in scope in order to find those funds.

ALFA D'AMATO: I can confirm that there is not. We haven't compromised any of the capital because, effectively, that is not a capital expenditure.

The Hon. BRONNIE TAYLOR: Thank you, Mr D'Amato. Could you take on notice where those savings came from?

ALFA D'AMATO: Sure.

## RESPONSE

I am advised:

Please refer to comments from Mr Alfa D'Amato on page 55 of the transcript.

## TRANSCRIPT PAGE 48

The Hon. SUSAN CARTER: Do you have any feedback or have you done any analysis of how successful rolling out accommodation has been in attracting suitable staff?

LUKE SLOANE: The districts have evaluated how much they've used at the moment, and that's still being worked through in its entirety — the program of getting the pods actually on the stilts, on the sites. I think I'd be just going off anecdote at the moment with regard to feedback from clinicians that then don't have to look for or are more happy to go out for shorter stints in some of the regions that need more critical workforce, knowing that they can go out there and the accommodation that's been set up already is lovely and they feel like they can be at home there, whether it's for a week or several weeks that they need to provide.

The Hon. SUSAN CARTER: Mr Sloane, could you take on notice and perhaps provide us with details of how much accommodation has been provided in which particular hospitals?

LUKE SLOANE: Yes, absolutely. I can take that on notice.

The Hon. SUSAN CARTER: That would be great. Thank you.

## RESPONSE:

I am advised:

Please refer to the response provided to questions taken on notice on pages 48-49 of the transcript.

## TRANSCRIPT PAGE 48 - 49

The Hon. SUSAN CARTER: I just have one follow-up question, if that's all right, first. Mr Sloane, in your answer you mentioned seeking budget enhancements. How much extra money do you need to be able to fund adequate accommodation for workers at hospitals?

LUKE SLOANE: It's a difficult figure to put our finger on right now. We're working through that process at the moment to understand what that means. The unit of measure for how much exactly we need can range from bedrooms to — that might look different depending on the type of accommodation that's actually needed. It's as long as a piece of string if we're talking about a lot of the places that have been affected by natural disaster or otherwise, but that's something we're going to be working through over the course of the next year.

The Hon. SUSAN CARTER: Thank you.

REBECCA WARK: You mentioned before Griffith, which is in the Murrumbidgee Local Health Murrumbidgee. That has been at the prioritisation of the district.

The Hon. SUSAN CARTER: If you could provide details of any hospitals with that accommodation, I'd be very grateful if you could take that on notice.

REBECCA WARK: I can keep going, if you like.

## RESPONSE:

I am advised:

At February 2024, there are 99 NSW Health facilities across the 9 regional local health districts with on-site health staff accommodation, or with health staff accommodation under construction.

Local health districts also use a range of health staff accommodation that is not on-site to attract and retain staff in regional areas.

## TRANSCRIPT PAGE 50

Ms ABIGAIL BOYD: I have one more question about consultants. I did noticed in that last audited report that one of the engagements that was disclosed was for PricewaterhouseCoopers and it was just under $800,000 — a project called "Design the Future Possible" for the people and culture Future Health project, which sounds very consulting-y. Can you tell me what that $800,000 was spent on?

PHIL MINNS: I can, Ms Boyd. NSW Health has a Future Health strategy, which is about the next decade plus, and we made the decision to have a complete sweep of the entire people and culture teams throughout NSW Health — the ministry, the pillars, the statewide services and all the districts and networks — because we think that we haven't taken a strategic look at how we are set up, how we are structured and how we are performing in all of those different contexts because the system has been, since the establishment of the districts, pretty devolved with respect to how people and culture functions operate. It was a very, very considerable deep dive. It looked at comparable-sized organisations in Australia and overseas, and that was particularly some of the value from PricewaterhouseCoopers.

There were many, many consultative sessions with staff right across the State, the purpose being to say, "Well, how do we benchmark as we are currently structured and operating? What are large employers, corporates and/or other large public systems doing in respect of how they run their HR functions?" I won't remember the recommendation's number; I'll have to take that on notice. A series of changing reform agendas — one of them I mentioned earlier today — was about recruitment. We're in the process now of implementing. The work we did with PricewaterhouseCoopers was really about taking our small team and making it bigger and able to do more consultation quicker as well as that international expertise and best practice advice on people and culture.

Ms ABIGAIL BOYD: How long did that piece of work go for that PwC was employed to do?

PHIL MINNS: I'll take that on notice, but it's more than a year.

RESPONSE

I am advised:

The work with PwC took 10 months – from 22 June 2022 to 28 April 2023. Consultation involved over 1,200 staff members, 26 Chief Executives, and 115 customers of the people and culture function. Additionally, 495 staff were involved in local people and culture department reviews.

PwC conducted a deep analysis of current state, reviews of leading practice of other large complex comparable organisations and an impact of the future of work on NSW Health.

NSW Ministry of Health was provided with recommendations on structure, function, and capability to optimise people and culture service delivery into the future. This included the generation of support tools and resources to assist with the change management in local teams.

Co-design methodology was used throughout the project with a high level of engagement across NSW Health organisations, teams, and individuals. This also facilitated skills transfer to the NSW Health project team. The independence and international footprint of PwC was critical to the project.

The project is continuing with the NSW Ministry of Health leading implementation of recommendations.

## TRANSCRIPT PAGE 50 - 51

Ms ABIGAIL BOYD: If I could turn to something completely different and I'm not sure, Ms Pearce, who to direct this to. I want to ask some questions around disability and disability training within Health. The first question I have is: Is there an intention to expand the specialised Intellectual Disability Health Service statewide for people with cognitive disability? So local health services and statewide.

SUSAN PEARCE: Could you just repeat that, sorry. Expand the?

Ms ABIGAIL BOYD: The specialised Intellectual Disability Health Service, I understand they're in some locations at the moment but not—

SUSAN PEARCE: Are you talking about the—you mentioned training at the start.

Ms ABIGAIL BOYD: Yes. I will get to that. This is—I'm being told it is something called the specialised Intellectual Disability Health Service.

DEBORAH WILLCOX: I would have to take the question on notice, Ms Boyd. My apologies. We do have an intellectual disability service, as you describe. We have a very—it's a centralised service so that we can make sure we identify the needs and help staff in our local health districts provide care to people with disability— intellectual disability—as they come into our mainstream health services for procedures and the like. On the specifics of our level of training and any decisions around expansion, I have to come back to you, but there's not a proposal on foot to expand at this point in time, to my knowledge.

Ms ABIGAIL BOYD: Thank you. What measures are currently being taken to upskill all New South Wales health practitioners in relation to cognitive disability health?

DEBORAH WILLCOX: Yes, it is a very important area. As I said, patients come into our care and bring all of their life and their issues with them. There is a large amount of work being led initially by the Australian Commission of Safety and Quality in Health Care, which has a very substantial package around cognitive disability and what staff need to consider, and the policies and the issues that need to be a part of care when an individual comes in with their carer or family. I can come back to you with detail on the training packages, but suffice to say it's a significant component of our accreditation and there are tools and resources in our local health districts to support staff.

Ms ABIGAIL BOYD: Maybe when you come back—what I am being informed is that there are only, sort of, short e-learning courses which are not mandatory

and not particularly comprehensive in this area. I would like to know if there are plans to beef that up, I guess.

DEBORAH WILLCOX: Sure.

Ms ABIGAIL BOYD: Does the Government have any intention to establish a disability deaths review scheme? I don't know if that would fall within your purview anyway.

DEBORAH WILLCOX: Not in my remit as far as I'm aware. I would have to take that one on notice.

Ms ABIGAIL BOYD: Are you able to tell me how many investigations there have been in the last financial year into the use of physical restraints on patients with disability in NSW Health settings?

DEBORAH WILLCOX: I'd have to take that one on notice.

Ms ABIGAIL BOYD: Is anything being done within the department to improve health data collection in relation to reducing fatalities and poor health outcomes for people with disability?

DEBORAH WILLCOX: I don't have specific advice for you on that. The outcomes of patients is something that we manage and monitor for all patients. So, I think, though in relation to people with a disability, we wouldn't have a separate reporting line around that. But, again, if there are any incidents or suboptimal outcomes for an individual in our care, they would be investigated and recommendations would be made as a matter of course, regardless of their circumstances.

SUSAN PEARCE: I might add, it has been an area of focus on that — and whether Matthew could add anything here. It certainly has been an area of focus in the past where we have encountered situations where a person's disability perhaps has contributed. The way they've been cared for may have been impacted because of the disability and presenting symptoms and the like. Those types of issues are dealt with very seriously and the Clinical Excellence Commission in the past has had a good look at those types of events. There have certainly been, over the years, a number of matters that have reached coronial hearings and the like, so any lessons learnt from those processes are shared with our staff. And we could take that on notice because I'm almost certain, although I'm slightly demented from last four years, that in the past we have absolutely had this issue raised at our peak safety and quality committee in respect of how our staff care for people with disability when they attend our hospitals.

RESPONSE:

**Is there an intention to expand the specialised Intellectual Disability Health Service statewide for people with cognitive disability?**

I am advised:

NSW Health specialised Intellectual Disability Health Service provides multidisciplinary health assessment and referrals for people with intellectual disability and capacity building for health professionals. This service is available across NSW.

There are no immediate plans to expand the service. A review of the service is being commissioned to inform future decisions.

**Does the Government have any intention to establish a disability deaths review scheme?**

I am advised:

This question should be directed to the Department of Communities and Justice.

**Restraints used on patients with disability**

I am advised:

The Clinical Excellence Commission has not conducted any investigations in the last financial year about the use of physical restraints on patients with disability.

**Patient Safety First Unit – Coronial hearings and lessons**

I am advised:

The Ministry of Health review coronial recommendations directed to NSW Health organisations from a state-wide perspective. State-wide guidance was provided following a coronial recommendation handed down in 2022 about disability inclusive health care. The advice included policy and resources available to staff supporting people with disabilities.

**What measures are currently being taken to upskill all New South Wales health practitioners in relation to cognitive disability health?**

I am advised:

In the HETI postgraduate psychiatry course, all psychiatry trainees do specific training sessions on working with people with intellectual disability. The content is determined by the RANZCP - syllabus and course provider. In the

HETI course this includes 6 hours of scheduled teaching and supporting resources.

## Training packages

I am advised:

NSW Health's Mental Health Branch has contributed to the funding of the Chair of Intellectual Disability Mental Health at the Department of Developmental Disability Neuropsychiatry (3DN) at UNSW, (www.3dn.unsw.edu.au/about-us) which has developed extensive training options and related resources for professionals and people with lived experience (www.3dn.unsw.edu.au/resources).

Mental Health Branch/HETI have a comprehensive set of resources developed with/at 3DN that will be available through *My Health Learning* for NSW Health staff.

3DN is part of the National Centre of Excellence in Intellectual Disability Health (funded by Australian Government) (www.3dn.unsw.edu.au/national-centre-excellence-intellectual-disability-health).

HETI submitted a list of training modules to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, detailing the course, description, frequency, and mandatory status offered to NSW Health staff.

In addition to the list provided to the Commissioner since then HETI has added numerous updated online modules in My Health Learning.

During 2023/24, HETI worked with the Council for Intellectual Disability to host a new learning pathway about delivering inclusive health care available for NSW Health staff on My Health Learning. The Council for Intellectual Disability has developed a series of 9 eLearning modules designed for health professionals to support inclusive healthcare. The suite of modules titled 'Just Include me – Inclusive Health Care' shine the light on person-centred care for people with intellectual disability. The learning pathway aims to increase the knowledge, skills and confidence of health professionals to work with people with intellectual disability. And improve health services and health outcomes for people with intellectual disability, their careers and families.

In line with the recommendations of the Disability Royal Commission, these modules will provide valuable specialist training and continuing professional development in disability health care.

## Reducing fatalities and poor health outcomes for people with disability

I am advised:

The Clinical Excellence Commission reviews all Serious Adverse Event Reports (SAER) as part of the Clinical Risk Action Group's remit. Patient demographics are collected including, when reported, intellectual disability.

## TRANSCRIPT PAGE 54 - 55

The Hon. SUSAN CARTER: Thank you. So 18 down to 10. The North Sydney LHD was proposing to develop palliative care support for people with dementia. Will that very important work still proceed as planned?

DEBORAH WILLCOX: I'd have to take that one on notice, Ms Carter. I'm not sure of the details there.

The Hon. SUSAN CARTER: If you could, I would be very grateful. Thank you very much. A number of local health districts were planning to hire bereavement counsellors for the parents of children who receive paediatric palliative care. Will those bereavement counsellors still be employed, given the reduction in the funding envelope for paediatric palliative care?

DEBORAH WILLCOX: I would need to look at the specific paediatric palliative care service plan that's been provided and see what the number of bereavement counsellors was. Again, I don't have that figure at hand, but I'm happy to take that on notice and attempt to get it back before the end of the session.

The Hon. SUSAN CARTER: That would be lovely. Thank you very much. In the same vein, the paediatric palliative care specialists, who would be hired as part of the Sydney Children's Hospitals Network — will those hires still proceed?

DEBORAH WILLCOX: The service plans that have been put in by the children's hospital would require a combination of staff — a multidisciplinary team — to provide the service. Just what that configuration is — I think you're on safe ground to assume a palliative care physician would be a part of that staffing model.

The Hon. SUSAN CARTER: Thank you. We touched on demand earlier as part of the reformatting of the funding envelope. Have you looked at expected increase in demand in palliative care? Do you have any models or any plans or research available that looks at the likely demand of palliative care over the next five years?

DEBORAH WILLCOX: We could certainly provide the Committee with any modelling that's been done. It would be, as a general statement, reasonable to say that with the medical interventions, research, personalised medicine and some of the genetic work that's being done, many diseases that would have led to early end of life or palliation, particularly in young people — unfortunately, diseases like cystic fibrosis — now people are having a much longer, healthier life. We have seen a flattening in some of these conditions

that previously would have led to end-of-life individuals. But, in terms of particular modelling, that would be something I would have to take on notice.

RESPONSE:

I am advised:

Please refer to comments from Ms Deb Willcox on page 64 of the transcript.

All local health districts have access to bereavement counselling services. This includes the NSW Government funded Integrating Grief Program and other bereavement support services through Griefline. These services can be accessed by the bereaved parents of paediatric palliative care patients.

District planning is still underway and will be based on local needs and tailored in-line with previous palliative care funding enhancements. Local health districts and speciality health networks - including the Sydney Children's Hospitals Network - can choose to boost their existing specialist bereavement services if that is a local priority.

While it can be challenging to obtain a true estimate of future palliative care needs and demands, evidence suggests that of the 50,000+ people who die in NSW each year, 70% could benefit from palliative care services. The NSW Government supports increasing demand for palliative care services in NSW by funding a range of end of life and palliative care activities.

The NSW Ministry of Health routinely collects data to monitor publicly funded activities and palliative care service delivery costs.

Northern Sydney Local Health District employs 3 nurse practitioners specialising in aged care who provide support for patients and their families based in residential aged care facilities. The most common diagnosis in this care setting is dementia.

The District employs a full-time bereavement social worker, based at Manly's Adolescent and Young Adult Hospice who provides bereavement services to families and carers of children and young adults aged 16 to 30 years.

## TRANSCRIPT PAGE 55

The Hon. BRONNIE TAYLOR: I'm going back to Mr Morgan because I have two more questions, I'm sorry. Actually, I think this is for Mr D'Amato. Could you please confirm if the money has been returned back to the City of Wagga Wagga?

ALFA D'AMATO: I'll take that on notice and confirm. We certainly received approval to return the money. I can also confirm the funding source was the Minister's contingency fund.

## RESPONSE:

I am advised:

On 19 October 2023, correspondence was sent to Dr Joe McGirr MP, Member for Wagga Wagga, advising that NSW Health had agreed to transfer $610,000 (ex GST) to Wagga Wagga City Council.

NSW Health is working with Council to process the payment in line with NSW Health policy and guidelines.

## TRANSCRIPT PAGE 56

The Hon. BRONNIE TAYLOR: I think the questions that will be coming up will be for Mr Sloane. Mr Sloane, my questions are in regard to the acute ward at Manning Base Hospital, which have been provided to me. I obviously can't verify any of this, but I'm just asking you these questions as it has been brought to my attention that patients deemed to have no decision-making capacity have been left stranded in the acute ward at Manning Base Hospital due to what people are saying is an issue that's going on with streamlining of these referral processes and these abilities. My question would be: How many aged-care patients deemed to no longer have capacity have been in the acute ward at Manning Base Hospital for 30 days or more? I presume you're going to have to take that on notice.

LUKE SLOANE: Yes, I would have to take that on notice and come back to you.

## RESPONSE:

I am advised:

At 22 February 2024, there were 5 patients without decision making capacity at Manning Hospital with a length of stay greater than 30 days.

## TRANSCRIPT PAGE 56

The Hon. BRONNIE TAYLOR: Deputy Secretary, may I ask you then, please—because I have been told about this, and it does really concern me, but, as I said, I'm not in a position any more to be able to verify that—could you undertake for the Committee to look at what's going on at Manning Base Hospital and these allegations that people are waiting for an unnecessarily long time when there are apparently some aged-care beds available?

SUSAN PEARCE: We certainly can do that. Can I just be clear, though, that there is a difference between beds available and staff beds available.

The Hon. BRONNIE TAYLOR: Understood.

## RESPONSE:

I am advised:

Hunter New England Local Health District continues to work with local non-government residential aged care facilities to ensure patients who require placement are transferred in a timely manner once cleared for discharge.

Some patients are waiting for placement for reasons beyond the District's control, such as waiting for Guardianship orders or an available bed in an aged care facility.

## TRANSCRIPT PAGE 57

The Hon. SUSAN CARTER: This is a question perhaps for you, Ms Pearce, in relation to the David Berry Hospital. Can you tell me whether all of the staff at that hospital will be transferred to the Shoalhaven Hospital or will any lose their jobs

SUSAN PEARCE: We might have to take that one on notice

DEBORAH WILLCOX: Yes, we'll come back to you, Ms Carter.

SUSAN PEARCE: We'll be able to come back to you during the course of the hearing.

The Hon. SUSAN CARTER: The other question I have in relation to that is that you may be aware that that land was actually given by the Berry family. Will you rule out the sale of the land on which the David Berry Hospital sits?

SUSAN PEARCE: We'll try to get an answer for you in the course of this afternoon. I just don't have that to hand right this second.

## RESPONSE

I am advised:

Please refer to comments provided by Ms Deb Willcox on page 58 of the transcript.

## TRANSCRIPT PAGE 57

The Hon. SUSAN CARTER: That's very good news. Thank you very much. I'm wondering also in relation to the Government's Medical Research Support Program, which is a major source of funding for a number of independent medical research institutes — Black Dog, Kirby Institute, Victor Chang. Concerns have been raised in this sector that this Medical Research Support Program is at risk of a substantial cut. This, of course, is a fund essential for the growth of a sustainable and highly productive medical research sector. Are there planned cuts to this program?

SUSAN PEARCE: We would need to take that on notice. The Minister for Medical Research is in a hearing today, and our colleague who supports that part of the portfolio is over there. So if we could take that on notice.

## RESPONSE

I am advised:

Information about the Medical Research Support Program, including application requirements and the annual funding pool for upcoming rounds, will be available on the Office for Health and Medical Research website at www.medicalresearch.nsw.gov.au/medical-research-support-program/

## TRANSCRIPT PAGE 59

The CHAIR: Thank you. I'm going to come back to Albury hospital, because I appreciate actually getting some bed numbers this morning after many, many months of the community asking for that. Can I follow up by asking how many operating theatres are going to be provided at Albury hospital?

REBECCA WARK: I think there's a clinical services plan which is in place, which Vince might be better placed to speak about. However, it's important to understand that we are currently in the concept planning phase of that, which is, as I mentioned this morning, around prioritisation of the scope and what's needed.

The CHAIR: Sure.

REBECCA WARK: And the clinical services plan, as I understand it, has not yet been released.

VINCENT McTAGGART: The number in the clinical services plan is 10 theatres.

The CHAIR: And how many ICU beds are we looking at?

VINCENT McTAGGART: If I'm not mistaken, the revised number is 12.

## RESPONSE:

I am advised:

The Albury Wodonga Regional Hospital project scope is informed by planning recommendations in the Albury Wodonga Health Clinical Services Plan 2022 review. It is also informed by revised NSW and Victorian governments infrastructure requirements advice, which outline what services and capacity may be needed to support healthcare delivery in the future.

The final project scope will be determined during the concept design phase that is currently underway.

## TRANSCRIPT PAGE 60 - 61

The CHAIR: This one might be back to Ms Wark, but I'm happy for either of you to answer. What discussions have been had with Transport regarding the Borella Road corridor in Albury and any upgrades that would be needed to accommodate the hospital redevelopment?

REBECCA WARK: I'd have to take that on notice.

The CHAIR: Have any of the road upgrades been included in the costings for the redevelopment?

REBECCA WARK: I'd have to take that on notice, but my preliminary answer would be no, unless it's immediately adjacent to the hospital as in ingress and egress.

The CHAIR: I look forward to that answer on notice. While you're taking these on notice, I assume this one will be too: What discussions have taken place between Health Infrastructure and Albury City Council?

REBECCA WARK: There is ongoing consultation with the Albury City Council and I understand that the project team briefs the council from time to time and answers queries.

The CHAIR: Could I get details of those meetings?

REBECCA WARK: Yes.

## RESPONSE:

I am advised:

Meetings with Transport for NSW were held on 20/03/2023, 12/07/23 and 19/12/23.

The meetings provided an opportunity to update Transport for NSW about planning for the Albury Wodonga Regional Hospital project and to discuss key considerations about transport planning and the surrounding road network capacity.

There is no allowance in the $558 million project budget for upgrades to Borella Road or the intersections on Borella Road at East Street and Keene Street.

Health Infrastructure has engaged with Albury City Council representatives throughout the hospital planning process on:

- 09/02/23 – Albury Council presentation on East Albury precinct plan and Albury Airport planning.

- 26/04/23 – Early consultation with Albury City Council to inform master plan development.
- 05/06/23 – Master plan development update.
- 12/07/23 – Precinct considerations (incl. Transport for NSW).
- 11/08/23 – Albury Council as part of Riverina and Murray Joint Organisation.
- 16/10/23 – Joint Albury and Wodonga Councils briefing to launch master plan consultation.
- 26/10/23 – Albury Council present as part of 16 x regional councils briefing on master plan.
- 22/02/24 – East Albury Precinct planning.

These meetings provided opportunities to engage with Albury City Council Executives, Councillors and Council Officers about the Albury Wodonga Regional Hospital project.

## TRANSCRIPT PAGE 61

The CHAIR: Moving to a completely different topic, the Federal Government has recognised the incredible work of the Waminda Birthing on Country program in Nowra with their $22.5 million investment to expand culturally safe care and wraparound support services. The New South Wales Budget Statement recognised the value and limited accessibility about chosen birthing on country programs, particularly in rural and regional areas. What of the gender equality budget commitments will fund chosen and expand programs like birthing on country?

SUSAN PEARCE: We will have to take that on notice.

## RESPONSE:

I am advised:

NSW Health Birthing on Country models of care are not funded through the gender equality budget commitments.

## TRANSCRIPT PAGE 62

Ms CATE FAEHRMANN: I wanted to turn back to the proposal that I spoke with the Minister about earlier today for the Broken Hill rehabilitation centre. I want to ask maybe you to begin with, Ms Pearce. Were you aware of that proposal?

SUSAN PEARCE: I feel like I had seen that document before, but I can't confirm it, I'm sorry. We'd have to have a look and see whether it's come to us.

Ms CATE FAEHRMANN: Anybody around the table, the many, multi-year campaign by the community of Broken Hill, who—I understand at the Broken Hill hospital several people, almost, a week who need help are turned away because there are no rehab services. It's quite shocking. Surely there has been an assessment of the need for a rehabilitation centre in Broken Hill and you're well aware of the community desperation and lobbying for a long time, including with the LHD, for this facility?

KERRY CHANT: I'm aware that there has been advocacy, I believe, to the Minister's office, but again we would have to confirm the nature of the correspondence with that group. I really need to speak to the team to see. Obviously the drug and alcohol section has been rolling out some commitments and funding opportunities through the ice special commission and there has been a prioritisation process. I'd really be happy to take it on notice, Ms Faehrmann, and explore what the needs are.

## RESPONSE:

I am advised:

The NSW Ministry of Health is aware of the proposal. Representatives from the Ministry's Centre for Alcohol and Other Drugs have met with the Broken Hill Alcohol and Other Drug Steering Committee several times about the proposal.

In 2023, the Steering Committee was notified of grant funding opportunities available under the Ice Inquiry.

## TRANSCRIPT PAGE 63

The Hon. BRONNIE TAYLOR: My last question, Mr Morgan, and then I've completed my line of questioning: Would you, or one of the people that work for you at a senior level, undertake to speak with the council about the concerns about the ambulance station and reaffirm to them the options that are available and what can be done?

DOMINIC MORGAN: That is something that is commonly done around the local community, so I'm more than happy to do it.

The Hon. BRONNIE TAYLOR: I think they are not really feeling it, Mr Morgan, because they wouldn't have come to me. It would be great if you would do that.

DOMINIC MORGAN: I'm always happy to talk to the councils.

## RESPONSE

I am advised:

A meeting is scheduled for mid-March 2024 with NSW Ambulance and Berrigan Shire Council.

## TRANSCRIPT PAGE 63 - 64

The CHAIR: I have one last question for Dr Chant before afternoon tea. I understand that after the SARS pandemic in other countries, like Canada, efforts were made for fit-testing for, particularly, respirators as PPE became a standard part of onboarding of new Health employees, rather than waiting for a pandemic to then roll out fit-testing. You would be aware of how protracted that process was during the peak of the COVID pandemic. Personally, working as a GP, it was more than a year into the pandemic before I was fit-tested. I was wearing non-fitting respirators for direct contact with COVID patients before vaccines came out. Is introducing fit-testing as a standard part of onboarding for NSW Health employees something that is being considered?

KERRY CHANT: I will have to direct that — apologies — to our infection control section within the Centre for Clinical Excellence. Probably one of the challenges is, as you know, fit-testing has to be particular to the brands, so one of the challenges is having the brands in sufficient quantities. We don't tend to use the P95s as much. Clearly use has really increased during the pandemic and we've been much more increasingly using those, recognising the importance of airborne transmission in a lot of settings. But having said that, it will have to be a continual revision to make sure that the products we're using at the time, that the staff are fit-tested. But I'll take that on notice and go to the Clinical Excellence Commission and see what the guidance is at the moment. But I would suspect there's more of an active program, particularly in areas that are higher risk, to have staff maintaining their skills and having repeated checks that they can meet those standards.

The CHAIR: I look forward to that answer on notice.

## RESPONSE:

I am advised:

NSW Health has developed an ongoing Respiratory Protection Program that requires implementation of a range of mechanisms to ensure appropriate selection and fit of respiratory protection and includes fit testing and fit checking.

Local health districts and specialty health networks are supported with a number of resources, including a comprehensive manual, education and learning modules and fit test assessor train the trainer found on the CEC website: Respiratory Protection Program. The likelihood of being required to wear a respirator is included, and risk assessed in all new onboarded staff.

## TRANSCRIPT PAGE 64

The CHAIR: I look forward to that answer on notice, which gives me time for one last question for Mr Minns. At the last estimates hearing I asked about the review of Birthrate Plus and you advised that the review would be completed around February or March of this year. Could you provide us an update?

PHIL MINNS: Unfortunately, Chair, the rest of the agenda around introducing safe staffing has pretty much preoccupied the taskforce. There is a parallel piece of work to the planning for ED rollout that is about Birthrate Plus but it's not yet complete. In my case, I have to recognise just how comprehensive and extensive the dialogue has been about how to go about introducing safe staffing, and even as we contemplate phase one, there are still things that we have to resolve before we can turn phase one on and one of those is the definition associated with agreement on regularly used treatment spaces in emergency departments.

The CHAIR: If I can have a very cheeky follow-up. Obviously it's really disappointing for midwives. Is there a revised time frame now for that review of Birthrate Plus?

PHIL MINNS: I'll need to get that for you; I might be able to get it in the break.

## RESPONSE

I am advised:

Please refer to comments from Mr Phil Minns on page 76 of the transcript.

## TRANSCRIPT PAGE 65

The Hon. SUSAN CARTER: An issue that's been identified to me by various stakeholders is that when training has been rolled out in hospitals, junior doctors are being given specific advice for how they manage around senior doctors who may be conscientious objectors. I wonder whether you thought that was an appropriate part of the health training in hospitals?

KERRY CHANT: I think the reality is the Act gives very clear roles of who needs to be involved in voluntary assisted dying. The approach we've taken in New South Wales is that voluntary assisted dying should be discussed with patients in the context of a broader discussion around prognosis and other treatment options, including palliative care, and integrated very much into the care environment. I'm happy to follow up examples of that, but that's not something we have been working very closely with the communities of practice and implementation groups on. We've been very conscious of making sure that our junior staff and our nursing staff that change over at the beginning of the year are given information about the services and what their responsibilities are.

For many of them it is raising it with their consultant, because one of the things that we're very conscious about is if a patient is asking about voluntary assisted dying on a ward round, that could mean that the patient is expressing that their pain is not being met and that they may well have an underlying depression. There may be very many other issues that need to be attended in a holistic way. We're being very clear about the need to document those things, to treat them in a clinical context and to give people pathways within the districts. But if you want to raise any questions where you think that could have been done better, I'm happy to take that on board and engage that with the local health districts. But, as I said, we've established a lot of communities of practice, because this hasn't been a one-size-fits-all implementation due to the fact that professionals do have their own ability to conscientiously object in this domain.

## RESPONSE:

I am advised:

The answer provided by Dr Chant in the hearing addressed the Member's question. In addition, Dr Chant discussed the matter with local health district executive leads at the 7 March 2024 Voluntary Assisted Dying Local Health District Implementation Working Group meeting.

## TRANSCRIPT PAGE 67

The Hon. SUSAN CARTER: We explored issues around some of the regional areas earlier today; Broken Hill is the very strong example that we've looked at. As part of this program, are there additional resources so that appropriate follow-up treatment is available to people subject to the diversions?

KERRY CHANT: Clearly, there is a large unmet need but the ice commission commitment of funds from the Government has been important at redressing that. There's obviously workforce challenges and other challenges at play. But I suppose just to say that the provision of telehealth has been, actually, a game changer, and the feedback from some of our rural/regional — where St Vincent's actually supporting the drug and alcohol services in those rural/regionals — has really assisted in access locally. Obviously we want to link in, and enable and work with GPs. This is an evolution. The investment has certainly increased the capacity and capability within our drug and alcohol services. But we need to work effectively with general practice and our non-government organisation sector, which is vital in the drug and alcohol space, as well as our own services.

The Hon. SUSAN CARTER: Telehealth — is it telephone? Is it audiovisual?

KERRY CHANT: It can be video. Currently, a number of the services do do video. Again, it will be tailored. We will continue to learn, continue to evaluate and also monitor what delivers outcomes.

The Hon. SUSAN CARTER: What identity checks are in place?

KERRY CHANT: There is a process through the way the fines are administered and the data that will need to be shared. I would have to take that on notice in terms of what details are captured and how we can prove it's the same person. I will have to take that on notice. But this is administered as a whole of government, linked to the fine, linked to Service NSW.

## RESPONSE:

I am advised:

People who access the health intervention will be required to provide:

- Fine notice number
- First and middle names
- Last name
- Postcode
- Date of birth

This information is submitted to Revenue NSW for validation to finalise the fine.

Revenue NSW has processes in place to match data to fine information through the NSW Police information system.

## TRANSCRIPT PAGE 68

The CHAIR: I'd like to come back to some of some of the staffing issues at Manning Base Hospital. I asked the Minister about this this morning, but I'd appreciate understanding some more of the detail. Is it possible to understand what Manning Base is currently spending on locums and whether that's increasing or decreasing?

SUSAN PEARCE: We would have to take that on notice.

The CHAIR: Similarly, what about staffing vacancies at Manning Base Hospital?

SUSAN PEARCE: Notice.

## RESPONSE

I am advised:

At 12 March 2024, around $7 million has been spent on locums at Manning Base Hospital for 2023-24. This is consistent with expenditure for the same period the previous year.

Manning Hospital's currently has 142 (headcount) vacancies across all staff cohorts, from a total headcount of 987. As many staff are part time or fractional, this equates to 55 FTE total vacancies.

At 6 March 2024, 50 FTE vacancies are being recruited to at Manning Base Hospital across all staffing cohorts.

## TRANSCRIPT PAGE 68

The CHAIR: Coming back to something else I asked about this morning, which was the budget commitment of $3.5 million to improve access to reproductive health services, including in regional New South Wales, and the Budget Statement noted the negative health outcomes for people with unintended pregnancies. Can you please break down how that $3.5 million is being spent?

DEBORAH WILLCOX: I'd have to take the breakdown on notice. I just have the global figure, as you do.

The CHAIR: On the same topic, the Minister gave quite a comprehensive answer this morning about what's being done to actually provide more abortion services in rural and regional areas, but I'm interested in understanding in the interim what's being done to address the significant cost and difficulty for people to access abortion in areas where there are no local services, particularly looking at places like Western and Far West. I understand, according to Family Planning, that AMSs, women's health centres and other organisations are incurring significant costs in providing transport and staff to attend services that are sometimes hundreds of kilometres away.

DEBORAH WILLCOX: The specifics I would need to get some further advice on, but as you are aware there is the Pregnancy Choices Helpline. The intent of that service is to give people advice on the nearest place from which they can safely receive an assessment and a service provider. Mr Sloane may be able to assist me with what local transport options may be available to someone in the State requiring these services.

LUKE SLOANE: Yes. In some occasions there would be support or assistance provided by the health district, but I wouldn't be able to—again, I'd be going off anecdote where that would actually be, whether it's a support worker or an Aboriginal support worker that would provide transport assistance to travel to another area or spot, like we do across a lot of health and medical specialties. I'll get my team to check how it interfaces with the IPTAA Scheme as well with regards to subsidies or otherwise for access to specialty services, but I'll have to come back to you after reviewing the policy.

The CHAIR: I would appreciate a response to that on notice.

## RESPONSE

I am advised:

The 2023-24 NSW Budget allocated an additional $3.5 million over 4 years to support access to reproductive healthcare, including in rural and regional

NSW. These funds will see $0.5 million spent in 2024-25, $1 million in 2025-26 and $2 million in 2026-27. To implement this commitment, in June 2023, NSW Health established a Safe Access to Abortion Care Working Group to review services and pathways in districts and identify next steps to ensure safe and affordable access to abortion services in NSW, especially in regional and rural areas.

IPTAAS can support people living in regional, rural, and remote areas of NSW who are required to travel more than 100km to access reproductive services. Fertility Services, Obstetrics, Gynaecology, Maternal-fetal Medicine, Paediatrics and Urogynaecology are IPTAAS eligible services. Surgical terminations have been approved as an IPTAAS eligible service at Family Planning NSW.

### Services in Far West Local Health District

In Far West Local Health District, a medical termination pathway that is managed through telehealth with gynaecologists in Mildura. The surgical pathway is currently through referral to Mildura Base Hospital where treatment is by a gynaecology registrar. This pathway is dependent on availability of clinicians.

All patients referred to Mildura are provided IPTAAS forms. The specialist completes them at their appointment. In the past, Maari Ma Health has also helped to support their consumers in accessing care away from Broken Hill if the IPTAAS process doesn't work for them (for example, to pay up front and then be reimbursed).

The District has not been able to secure a surgical termination of pregnancy pathway at Broken Hill Hospital due to workforce capacity.

### Services in Western NSW Local Health District

Western NSW Local Health District provides medical terminations through Orange, Bathurst, and Dubbo maternity units for early pregnancy complications. Termination care is also provided through these maternity units up to 24 weeks gestation, with consultation with the Maternal Fetal Medicine Unit Nepean for termination care from 18 to 24 weeks gestation. These terminations predominantly occur for pregnancy complications or fetal abnormalities.

**The District Women's Health Service** assists with:

- Navigating availability of termination service.
- Provide education to clients.

- Advocate for clients by coordinating appointments and inquiring about bulk billing options.
- Working with partnering services, including Aboriginal Medical Services, GPs, and termination providers, to assist clients with costs related to medical costs, transportation, and accommodation both within and outside the district.

Western NSW Local Health District partners with **Family Planning NSW** in the **SEARCH project**. The project aims to enhance access to abortion services and affordable **Long-Acting Reversible Contraception** methods, for women in regional, rural, and remote areas. The District aims to establish a virtual or face-to-face clinic in **Dubbo**, working alongside a GP to offer medical termination of pregnancy.

## TRANSCRIPT PAGE 69

The CHAIR: I understand that in 2021-22, which was the latest data I could find online, the number of potentially preventable hospitalisations for oral health was 21,303 people, and 57 per cent of dental presentations to emergency departments are preventable. Has there been cost-benefit analysis of this cost compared to the cost of expanding capacity and eligibility for public dental services?

KERRY CHANT: No, not that specific analysis. I think we recognise that we have done a couple of things in terms of making sure that dental needs are integrated within Healthdirect. Some of those needs do need to be seen. Some of those dental conditions will be trauma and they will also be associated with dental injury or they might be associated with other reasons. We are trying to put dental within the Healthdirect service so that people with certain conditions can be referred rapidly to general practice as well, where there might be conditions that are appropriate for general practice. I'm happy to take that on notice and consider that from the view of considering what else. But clearly there is an unmet need within dental.

## RESPONSE:

I am advised:

A cost-benefit analysis has not been undertaken on preventable hospitalisations for oral health.

## TRANSCRIPT PAGE 71

The CHAIR: The NSW Health Oral Health Strategic Plan states "NSW Public dental clinics will promote gender affirming spaces and inclusiveness in providing dental care to patients." How is that goal being implemented?

KERRY CHANT: I will have to look at the specifics to respond to that, but I would say that our services are really cognisant of the diverse communities which they serve and really aim to provide a safe environment. I can perhaps taken on notice some specific initiatives that have been put in place. But it is a key focus that our services serve many diverse groups, and we need to be welcoming in a safe setting.

The CHAIR: Absolutely. I'm happy for you to take that on notice. I was pleased to see it in the strategic plan, and I'm interested in understanding what that actually means day to day in practice.

## RESPONSE:

I am advised:

NSW Health is committed to ensuring that LGBTQI+ people receive high quality, safe, inclusive, and responsive health care, including in NSW public dental clinics.

NSW Health will promote gender affirming spaces and inclusiveness through staff training and education, creating a welcoming physical environment and by working with LGBTQI+ advocacy groups and non-government organisations.

## TRANSCRIPT PAGE 71 - 72

The CHAIR: Thank you. I hope you can also appreciate that there are two different pieces of communication missing here. One is the one with the broader general public, where there's confusion and lack of clarity around who's eligible and what they should be doing, but the second piece is with the pharmacies and with the practitioners. I think it's awful when people are being proactive and doing the right thing and turning up. If they're turned away, they don't try again and then the result is that people aren't getting vaccinated, which is the opposite of what we want.

KERRY CHANT: That's right. We would encourage the pharmacies to ring our public health units, who could assist them as well in reassuring them about the eligibility, if there's any confusion. Let me take that away and we'll see what we can do to support better information and what the information gap is.

The CHAIR: Just to clarify for the record, when updated vaccines become available to keep up with emerging strains of COVID, it's not the case that practices or pharmacies have to use up the old stock before they are able to use new vaccines?

KERRY CHANT: That is a matter for the Commonwealth and I would just need to check whether the Commonwealth has put any guidance out. I would not have thought so. I think it was important to say though that all of the vaccines help and clearly the newer vaccine is the preferred one. But the vaccine you have is better than the vaccine that you don't have, particularly in the context of high community transmission where your likelihood of coming into contact with COVID is highest. That's been one of the issues that we were trying to get out last year when everyone knew the new vaccine was coming and perhaps waiting. If you are in a very high risk category that's probably not desirable. But let me take that on notice in terms of understanding what the Commonwealth might have been communicating.

The CHAIR: The last follow-up to that is, are you aware of any supply issues that might mean that people are being told that they are not eligible? If a fit, healthy adult wants to do the right thing and have a booster, is there a reason that they shouldn't be eligible or told they can't have one?

KERRY CHANT: I'm not sure there should be any supply issues. But, again, it may be the fact that obviously the ATAGI advice is requiring a very nuanced approach to those outside — it's very clear for the over-65s and it's a little bit more nuanced for the other groups. That may be adding to the confusion about what pharmacists are permitted to do. Let me follow that up and I will

talk to the Commonwealth about any materials they have sent them out and see if we can be a bit clearer in our advice.

## RESPONSE

I am advised:

The Australian Government leads the COVID-19 vaccination program and considers the advice of the Australian Technical Advisory Group (ATAGI). ATAGI provides clinical guidance on the use of COVID-19 vaccines in Australia, including recommendations on a COVID-19 booster dose. The Australian Government Department of Health and Aged Care distributes regular COVID-19 Provider Bulletins to provide COVID-19 vaccine updates to immunisation providers, including vaccine ordering, recommended vaccines and population groups for whom vaccination is recommended.

After receiving concerns for confusion about the eligibility for the COVID-19 vaccine booster dose in late 2023, NSW Health contacted the Australian Government's Vaccine Operation Centre (VOC) and the COVID-19 vaccination policy team at the Department of Health and Aged Care to suggest further communications to help immunisation providers and members of the public understand the eligibility and reasons. Advice about COVID-19 vaccine recommendations were included in the Commonwealth's 18 January 2024 COVID-19 vaccine provider bulletin.

ATAGI has provided the latest advice on COVID-19 vaccine booster dose on 29 February 2024. The recommendations are as follows:

- a dose of COVID-19 vaccine for adults aged 75 years and over every 6 months.
- the following groups receive a dose of COVID-19 vaccine every 12 months, and can consider a dose every 6 months, based on a risk-benefit assessment:
    - adults aged 65 to 74 years.
    - adults aged 18 to 64 years with severe immunocompromise.
- the following groups can consider a COVID-19 vaccine every 12 months, based on a risk-benefit assessment:
    - all other adults aged 18 to 64 years.
    - children and adolescents aged 5 to less than 18 years with severe immunocompromise.

This advice is now simpler for consumers and immunisation providers.

This latest advice is readily available to providers and consumers. This includes publication of the advice on the ATAGI webpage and circulation by the Department of Health and Aged Care to all COVID-19 vaccination providers through the COVID-19 vaccine provider bulletin. The bulletin was shared with key NSW Health providers including local health district COVID-19 vaccination program contacts and public health units. NSW Health webpages are also being reviewed and updated to reflect the new recommendations.

The Department of Health and Aged Care has stated that COVID-19 vaccines remain funded for eligible individuals. This includes people in the above groups and people aged 5 years and over who have not previously had a COVID-19 vaccine.

ATAGI has indicated that XBB.1.5-containing vaccines are preferred over other COVID-19 vaccines.

Further information on the COVID-19 vaccine booster advice is available on the Australian Government website at www.health.gov.au/resources/publications/atagi-statement-on-the-administration-of-covid-19-vaccines-in-2024.

Immunisation providers should contact the Vaccine Operation Centre at 1800 318 208 or covid19vaccineoperationscentre@health.gov.au for COVID-19 vaccine advice, including access to vaccines and eligibility for vaccination.

NSW Health encourages people to discuss eligibility for COVID-19 vaccination with their healthcare provider who will provide advice and support as required prior to their vaccination.

## TRANSCRIPT PAGE 73

The Hon. BRONNIE TAYLOR: That's okay, that's all I wanted to know. Thank you very much, Mr Minns. Ms Wark, my next question is going to be for you. I want to talk about Finley Hospital. I understand there is a $25 million commitment to the upgrade of Finley Hospital.

REBECCA WARK: Yes, that's correct.

The Hon. BRONNIE TAYLOR: I am told, and again I wasn't there, that the community has been disappointed with the concept plan and that a meeting was held where nine people from Health Infrastructure and Murrumbidgee Local Health District attended. Would that be correct?

REBECCA WARK: I understand there have been a number of meetings and I think you may be referring to an online meeting, not a face-to-face meeting. But I'm not sure. I'd have to take that on notice.

## RESPONSE:

I am advised:

On 4 December 2023, Murrumbidgee Local Health District met with representatives from Berrigan Shire Council and Finley Local Health Advisory Committee about services and models of care at the Finley Health Service.

On 6 December 2023, representatives from Murrumbidgee Local Health District (5), Health Infrastructure (2) and consultant project managers (2) met with Berrigan Shire Council to provide a briefing and listen to feedback following the release of the early designs of the Finley Health Service Redevelopment. Health Infrastructure representatives and the project manager attended online. Local health district stakeholders were onsite at Berrigan Council chambers.

The project team continues to liaise with all stakeholders.

## TRANSCRIPT PAGE 73

The Hon. BRONNIE TAYLOR: Ms Wark, I'm wondering if it would be reasonable to assure the community, because we know that often when these things happen, when people can go and discuss it with people face to face, we tend to be able to allay communities' fears and have reasonable discussions. You have built billion-dollar hospitals everywhere—it must be very exciting. The Tweed must be very exciting. Sorry, I digress. I am just wondering if you could assure the Committee that perhaps someone on top of what has happened with this online forum would be able to speak to Finley council to reassure them about the issues they have about the upgrade of this hospital.

REBECCA WARK: I will certainly look into that. I am aware of the meeting which you're talking of and I will speak with Mr Sloane and also Jill Ludford at the district around what we need to do in that space. I think it is fair to say that Finley hospital is like many of our projects where we are now under significant budget pressure because of the escalation issues that we're facing and what we may have been able to afford when the project was announced is no longer able to be afforded. We are working through that with the community and the local people there about what we can do, and I understand that is still a mix of new build and refurbishment.

## RESPONSE:

I am advised:

Contact will be made with Finley Council.

## TRANSCRIPT PAGE 75

The Hon. SUSAN CARTER: There is concern in relation to local Hawkesbury suppliers, services, businesses and contractors who currently support Hawkesbury hospital. Will they be disadvantaged as a consequence of NSW Health procurement policies when the hospital is transferred?

DEBORAH WILLCOX: The transition from St John of God, which determined not to continue with the contract, is underway and won't be completed until the end of June, at the end of this financial year. Part of the transition work we're doing with St John of God is to look at things that you just highlighted: contractors, the imaging suppliers. They have been part of St John of God and so all of their supply chain contractors and the like have all been managed through them as a private organisation. As we step through the transition, that will be a critical part. Firstly, supply chain needs to be maintained. As you would be well aware, we have HealthShare, which provides food and linen and some warehousing services for our local health districts. We would expect there would be some changes from private suppliers back into Health supply chains. We would obviously be looking to optimise value for money for our health services; led by Mr D'Amato, the procurement activity is pretty significant across Health. We look to get those opportunities for the Nepean local health district as St John of God moves in. We will work with all the suppliers and the contract staff who are currently caring for patients in St John of God.

The Hon. SUSAN CARTER: Happily, parking at that facility is currently free. Will that be maintained with the transfer?

DEBORAH WILLCOX: I can't answer that question directly, but the hospital is coming into the public health system. It would only appear to be equitable to have the same rules apply to those staff who will now be part of the public health system and not have the different arrangement.

## RESPONSE:

I am advised:

Nepean Blue Mountains Local Health District will continue to serve the Hawkesbury community. The District is currently reviewing contracts in line with NSW Health Procurement Policy.

Parking fees are not planned for Hawkesbury Hospital.

## TRANSCRIPT PAGE 76

The Hon. SUSAN CARTER: Last question from me, if anybody can help me: When will the Bega safe haven open?

DEBORAH WILLCOX: I've probably got a note on that, but I can take that on notice. The Hon.

SUSAN CARTER: Thank you. That would be lovely.

## RESPONSE:

I am advised:

The Bega Safehaven opened on 29 February 2024.

## TRANSCRIPT PAGE 77

The CHAIR: First they came for Fair Day; then they came for the safe haven. I asked at the previous estimates about what is being planned for the old Tweed Hospital site now that the new Tweed Hospital is opening. Ms Wark, at that hearing, advised that the deliberations were underway. Are you able to now advise whether that's going to be used for a health service or for another use?

REBECCA WARK: I think those deliberations are still underway. My colleagues in the Ministry of Health property are liaising with Property NSW about the ongoing use of part of that site. Certainly, in the new term the district will be keeping one part of the site. There is a breast screening service which will operate from there. There are also some other district administrative functions which will operate out of one of the buildings there.

The CHAIR: So other than BreastScreen and those administrative officers, is my understanding right that now the rest of the site is going to be transferred to Property?

REBECCA WARK: I can't confirm about the transfer, but certainly, as far as the project is concerned, we're not doing any further work on that site. There's also an ambulance station on the greater site as well.

The CHAIR: Which is going to be retained?

REBECCA WARK: There's no current plan for that to be moved, that I'm aware of.

## RESPONSE:

I am advised:

Northern NSW Local Health District plans to maintain current BreastScreen NSW services at Powell Street, Tweed Heads.

The District will also provide a range of community-based and outreach health services to be co-located with BreastScreen at the current Tweed Hospital, following the transfer of health services to Tweed Valley Hospital later this year.

There are no plans for NSW Ambulance to relocate from its current site at Tweed Heads.

## TRANSCRIPT PAGE 77

The CHAIR: Mr Sloane, I was hoping you might be able to provide an update about the Collaborative Care Program that I understand the Rural Doctors Network is undertaking on five sites. I asked previously about scalability assessments of that project. I was particularly excited to hear about the State Government supporting primary care access in regional areas. How's the project going?

LUKE SLOANE: As you may recall we work with the Sax Institute to work with all the stakeholders at those five sites to conduct the scalability assessment. That has been finalised and I'm more than happy to provide you with a copy of that. It validated a lot of our thoughts and thinking around small communities and how healthcare in those spots where collaborative care is currently set up, work and rely on trust with the community, really great communication and connecting all the different parts of what's the provision of healthcare in those areas. We are now working through the process of identifying further areas where we'll work with Rural Doctors Network and the other stakeholders in communities to roll that out further. We have two tentative sites that we're working with at the moment — one being Leeton and the other one being Wee Waa. We've had early conversations with both of those towns and their communities, and also with Leeton council as well, to be able to work with them, coordinate it all and get that in place. So it's very positive at the moment.

We're also very aware that there are other models of collaborative care that perhaps aren't documented or written up. We know there's really strong work happening in that space in places like Gunnedah, where they've got primary care working with the Aboriginal Medical Service and the LHD and other stakeholders in the one spot to be able to divert people away from emergency, as well as provide that really good quality, holistic primary care. We'll continue to work on that because we can see it's got real benefit in small communities and to make sure that we're working with not only the GPs in town to support them and make sure that the community has wraparound healthcare that suits its needs that's not necessarily definitive acute care, and that's working on prevention. Kerry and I have discussed this recently — working on prevention, health promotion and actually targeting some of the more preventative needs of the community as we work forward.

RESPONSE:

A copy of the *Collaborative Care & Place-based Planning Approaches* report has been provided to the Committee.

## TRANSCRIPT PAGE 78

The CHAIR: I've got a question I think that's going to be for Ms Pearce. There's been a lot of coverage in the media of the Government's proposed legislation to ban conversion practices in New South Wales. That was an election promise that's been somewhat delayed. Given that there are some instances of conversion practices occurring in health settings, what consultation has been sought from Health? Have you been contacted by the Attorney General?

SUSAN PEARCE: I'd have to take that on notice.

## RESPONSE:

I am advised:

The NSW Government has established a joint working group with the Department of Communities and Justice and the NSW Ministry of Health to advise and give effect to the election commitment to ban 'LGBTQ+ conversion practices' in NSW.

To develop a legislative model right for NSW, the working group has led a targeted, confidential consultation process with a range of stakeholders including victim-survivors, LGBTIQ+ advocacy groups, faith-based organisations, parental rights groups and legal, government, education and health stakeholders.

The Government is considering the extensive feedback arising from the consultation.

## TRANSCRIPT PAGE 78

THE CHAIR: Thank you very much. Sorry, I just missed one about Tweed Hospital. I asked about the previous site. I understand that the new Tweed Valley Hospital's a 40-minute trip by public transport and that there's some concern from practitioners and consumers of the methadone clinic that that's now being relocated to the new hospital. Is anything being done in the short term to support those patients who are now having to travel quite a long distance to access the methadone clinic?

REBECCA WARK: I'm not familiar with that program, but we can certainly take it up with the local health district chief executive.

KERRY CHANT: I would be happy to follow up that program. One of the things that we're very keen to do is also partner with our colleagues in pharmacy, who can provide both methadone, but also buprenorphine, long acting. We have really got a strong focus in supporting pharmacies improve access to that option for clients. But I am happy to follow up the issue in relation to the clinic.

## RESPONSE:

I am advised:

Northern NSW Local Health District, Tweed Opioid Treatment Service, is supporting patients through the transition of the service to the new Tweed Valley Hospital site in Kingscliff.

Strategies include transitioning patients to long-acting treatment options where clinically appropriate, connecting patients to local prescribers and pharmacies if needed, and providing clear information on transport options.

## TRANSCRIPT PAGE 78 - 79

The CHAIR: Coming back to Mr Minns — sorry, I am very out of order at the end of the day — I am interested in coming back to junior doctors. You would well be aware of the class action in both New South Wales and Victoria regarding unpaid overtime. What work is being done to address this issue? I'm sure you are aware of the issue where junior doctors feel bullied or pressured by hospital administration not to claim overtime and that that's affecting their career progression.

SUSAN PEARCE: I'm sorry, I have to object to that, Dr Cohn. I think that's an unfair statement, to say that they feel bullied or pressured by hospital administration in this case. That's a very broad statement and I don't think it accurately reflects what has in fact led to that within the supervision of junior medical doctors over many years, which is also part of the problem.

The CHAIR: I'm aware that that's the experience of some junior doctors. I'm happy to correct the statement to make it less broad.

PHIL MINNS: Chair, I can't talk about the class action matter. It is the subject of ongoing legal conversations, including mediation. The department, the ministry, together with all of the LHDs and networks, has done an extensive amount of work over a four- or five-year period to try to create dashboards, policies, frameworks, information, new opportunities to claim overtime, an app for junior doctors to be able to easily claim their overtime, and I think we track — it gets tracked in the annual survey that occurs with the Australian Medical Council. I think there's a question in there that asks about their ability to claim overtime. If I can take that on notice I will get you the most recent data from that. We have seen improvement and my memory is — but the data will prove it on notice — that New South Wales' percentage of people saying they regularly claim their overtime is better than the rest of the States. But that will be confirmed, if my memory is completely accurate, by what we supply as a response on notice.

The CHAIR: Thank you. I would really appreciate that data on notice. It will be very interesting.

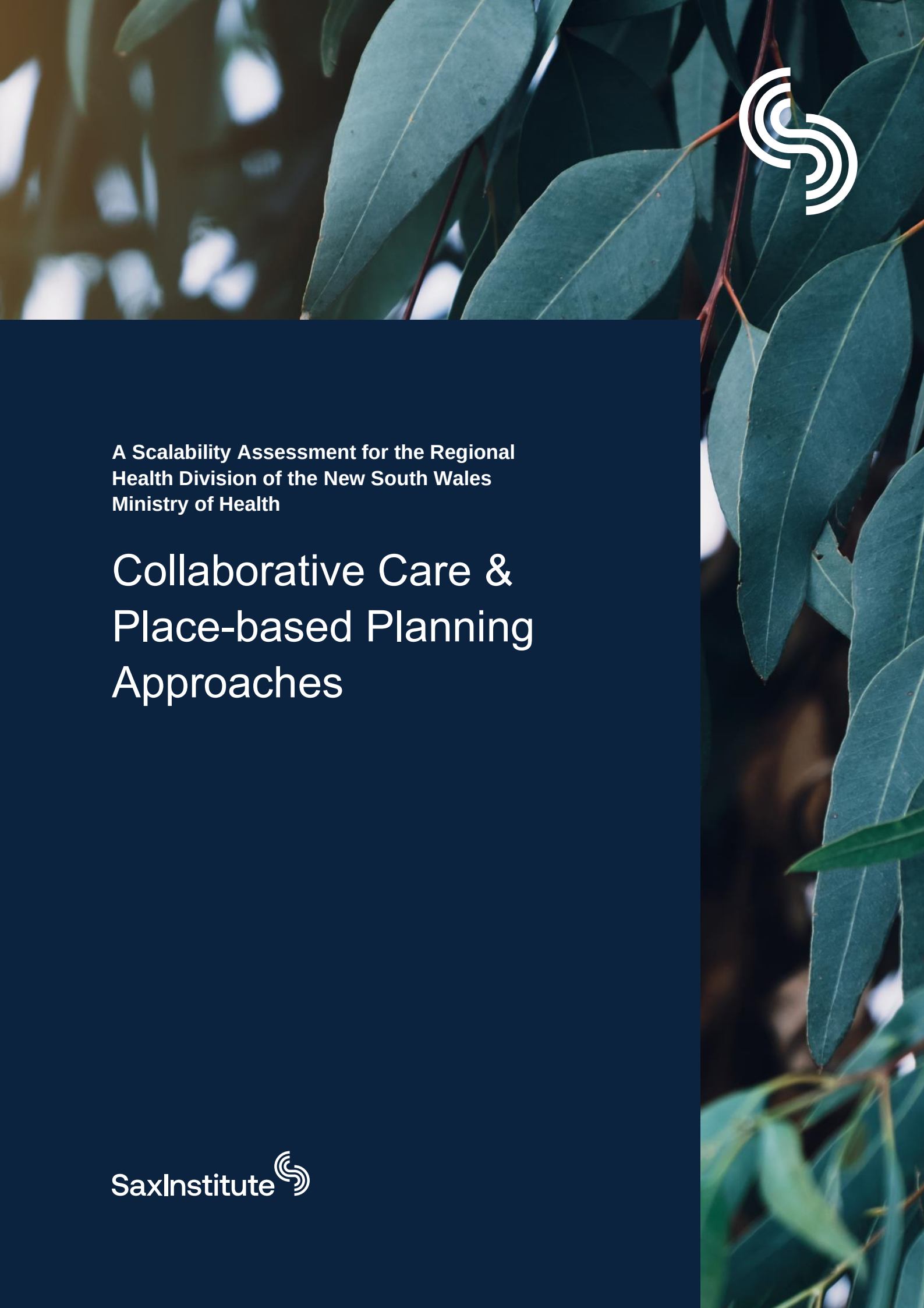
## RESPONSE:

I am advised:

The Medical Training Survey (MTS), administered by the Medical Board of Australia, shows year on year improvement in the number of junior doctors reporting that they claimed/ are paid for unrostered overtime worked.

**Medical Training Survey Results 2019 to 2023 – NSW and National**

| **How often did you get paid for unrostered overtime?** | **2019** | | **2020** | | **2021** | | **2022** | | **2023** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | NSW | National | NSW | National | NSW | National | NSW | National | NSW | National |
| **Always** | 27% | 25% | 31% | 26% | 36% | 29% | 43% | 34% | 49% | 41% |
| **Most of the time** | 23% | 22% | 28% | 24% | 29% | 26% | 28% | 27% | 27% | 27% |



A Scalability Assessment for the Regional Health Division of the New South Wales Ministry of Health

# Collaborative Care & Place-based Planning Approaches

SaxInstitute

A report by the Sax Institute for the Regional Health Division of the New South Wales Ministry of Health. December 2023.

This report was prepared by: The Sax Institute. December 2023.



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**A report by the Sax Institute for the Regional Health Division of the Ministry of Health.**
**December 2023.**

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# Glossary & Abbreviations

**ACCHO:** Aboriginal Community Controlled Health

**AH&MRC:** Aboriginal Health & Medical Research Council

**AMS:** Aboriginal Medical Service

**DTBC:** Deliberate Team-Based Care

**GPs:** General Practitioners also

**IMOC:** Innovative Models of Care grant scheme

**IT:** Information Technology

**LHD:** Local Health District

**NGOs:** Non-Government Organisations

**NSW:** New South Wales

**4Ts model:** A model of healthcare within the Collaborative Care Program based in regional NSW and named after four communities in Central Western New South Wales (Tullamore, Trangie, Tottenham, and Trundle)

**PHN:** Primary Health Network

**Place-based planning:** An approach that takes into account the specific context of a geographic location through collaboration and shared decision making with the local community

**PRISMA:** Preferred Reporting Items for Systematic Reviews and Meta-Analyses

**RHD MoH:** Regional Health Division at the Ministry of Health

**RDN:** Rural Doctor's Network

**SME:** Subject Matter Experts

**WHO:** World Health Organization

# Executive summary

## Background

The Regional Health Division of the Ministry of Health (the RHD MoH) commissioned the Sax Institute to complete a scalability assessment of Collaborative Care and place-based planning approaches. Collaborative Care can be considered an ***approach*** that can be put in place to support communities to develop solutions to local primary care challenges, rather than a prescriptive ***model of care*** that can be implemented similarly in different communities. A critical element of the approach is its in-built flexibility, which enables intervention at the various stages of development of site-specific models of care; from the initial planning stage, through to a model being implemented as 'business-as-usual' in a community. This flexibility ensures the approach can support communities at different stages of readiness for a model. The following report describes the aims, background, methods, and findings of the Sax Institute's scalability assessment.

## Aims

This scalability assessment aims to:

1. Understand how the Collaborative Care approach works and the factors that support its success
2. Understand the role of RHD MoH in scaling the approach.

## Summary of Methods

Two key data sources were used:

1. A rapid thematic review of published literature on place-based planning approaches in Australia and internationally. The review focussed on enablers and barriers of implementation and scalability.
2. Consultations with:
    a. Individuals involved in the development of the Collaborative Care Program
    b. Individuals involved in the development of one of the five specific models of care
    c. Individuals with knowledge of the NSW Health system and regional NSW context.

The ExpandNet/World Health Organization's (WHO) published framework[1], which outlines a process for scaling up, was used to organise and align emerging themes from both the review and the consultations[1].

[1] Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up, World Health Organization, 2011

# Key Findings

When examining how Collaborative Care and other place-based planning approaches function, a total of four distinct themes, each comprised of 3-4 subthemes, were identified from stakeholder consultation (n=22 people) and literature review (n=17 publications). These themes and subthemes are summarised in Table 1.

**Table 1. Themes and Subthemes**

| Theme | Subtheme |
|---|---|
| **1. Stakes / Interests** | **1A:** Ensure a multidisciplinary, whole-of-system, coordinated approach (Invite everyone to collaborate) |
| | **1B:** Identify and articulate mutual interests (What is the benefit of collaborating?) |
| | **1C:** Declare and manage competing and conflicting interests (What other agendas could put collaboration at risk?) |
| | **1D:** Appoint an impartial intermediary to facilitate the collaboration (Who would treat everyone equally?) |
| **2. Trust / Time** | **2A:** Adjust project timeline to accommodate historical trust and distrust between collaborators, facilitators, and communities (How ready are we for collaboration?) |
| | **2B:** Facilitate the establishment of trust through transparent communication and consistent action over time (Always say what you will do, and do what you have said) |
| | **2C:** Prevent or manage the rapid breakdown of trust (How can we prevent or quickly resolve problems?) |
| **3. Power / Influence** | **3A:** Identify a committed local health service with sufficient capacity and flexibility for innovation (Who makes decisions about local health services?) |
| | **3B:** Identify complementary local resources and leadership (Who makes decisions about the resources that could help the health service?) |
| | **3C:** Structurally counter power imbalances between collaborators, facilitators, and communities (How can we ensure everyone contributes to decisions?) |
| **4. Knowledge / Expertise** | **4A:** Recognise local knowledge of resources and needs as essential to success (Learn the route from local drivers familiar with the roads) |
| | **4B:** Apply complementary technical and subject matter expertise to co-design solutions (Share or source an engineer's understanding of the car) |
| | **4C:** Upskill in cultural safety and support, particularly for First Nations communities (Learn how to include everyone's expertise) |

When examining the NSW context into which the approach might be scaled, participants with broader experience in the NSW context (n=4) provided advice on how to be more inclusive or engaging, especially with First Nations communities. Suggestions were provided for ways existing NSW services could be leveraged, and how redundancies might be streamlined to enable the approach to be scaled

up across the state. The data also highlight the importance of allowing sufficient time and resources to successfully navigate through existing relationships.

## Recommendations

The findings of this report point to the RHD MoH playing the role of the facilitator in a Collaborative Care approach. This could mean facilitating the establishment of a new collaboration or stepping in to support an existing collaboration. This facilitation role will likely be more direct and resource intensive when seeking to establish new collaborations, but there may be times during the life of a collaboration when there is minimal to no involvement required and the role of the RHD MoH is to support and empower people and organisations to actively take on the role of a facilitator.

In short, the role of the facilitator is to establish strong scaffolding for the building of a Collaborative Care approach. This scaffolding can be dis-assembled, but only once the foundations for a strong and sustainable collaboration have been established. The collaboration may need attention down the track, which may require the scaffolding to be re-assembled, and the facilitator should be available and willing to offer support should remedial action be necessary.

We offer the following recommendations, grouped by theme, to support the RHD MoH's understanding of what their role, as the facilitator of a Collaborative Care approach in NSW, could be:

***Stakes / Interests***

- When a new collaboration is being established, seek to identify and invite all relevant local health and community stakeholders (collaborators) to collaborate from the outset. Relevant collaborators could be identified via consultation with key individuals familiar with local resources, politics, and history of the local area, or via a snowball recruitment of groups or individuals who local community members believe should or could be involved because they have a personal or professional interest, or stake, in the outcome
- In the early establishment phase of a collaboration, clearly articulate the benefits of collaboration, encourage/foster collaborators willingness to commit in-kind time and resources, and emphasise that mutual or conflicting interests should be identified and communicated early as a foundational building block for successful collaboration
- Support the establishment of processes from the outset that allow collaborators to reflect on, formally declare and then manage, their objectives and interests in a safe and transparent manner, such as disclosure to an impartial intermediary where interests may be confidential or sensitive. These processes should be embedded in the routine operations of the collaborative so collaborators can regularly reflect on and declare any emerging interests throughout the life of the project
- Where possible, identify and support the appointment of an impartial intermediary to coordinate the collaboration (the coordinator). Specifically, someone who is not an employee or representative of the interests of any specific collaborator
- Support the development of recruitment processes for the coordinator role that emphasise the need for transparency and impartiality, and strong community engagement, leadership, and an 'arms-length' approach
- Given the importance of the coordinator role, consider not proceeding with a collaboration until a suitable appointment has been made.

***Trust / Time***

- Be aware of longstanding histories of competition between potential collaborators which could impact collaborative efforts. Inversely, there may be a long history of successful collaboration which could be leveraged. These preconditions will affect project timelines and budgets and therefore community readiness to participate
- Allocate time for the establishment of trust when planning collaboration timelines and budgets. If there are histories of distrust in communities, we recommend a timeline of five to seven years, and no less than three years
- Manage expectations of what can be achieved in a particular timeframe with a certain amount of funding to avoid the erosion of trust in the funder when, and if, the funding comes to an end
- Appoint coordinators with established community trust, and (where possible) ensure they are not employed by one of the collaborating parties
- Maintain integrous, transparent communication from facilitators regarding procedures
- Publicly communicate, recognise and celebrate collaborators and what has been achieved (e.g. via the media)
- Ensure evaluation of outcomes and implementation is considered at the outset of a collaboration to enable robust data collection and rigorous evaluation in the future
- Where time may not allow for trust to be developed, enshrine and communicate the values of equality and collaboration in project management and governance processes. For example, Terms of Reference, policies, funding criteria, data collection processes, and recruitment criteria
- Support the establishment of trust through transparent communication and consistent action, particularly when newly introduced collaborators are working together for the first time, or when there is distrust or broken trust between collaborators, or with the facilitator
- Proactively manage breaches of trust between collaborators by “refereeing” misaligned behaviour, and use the above governance processes (e.g. Terms of Reference) as a mechanism for managing misaligned behaviour
- Consider how to achieve balance between ‘not just meeting for meeting’s sake’, something government stakeholders traditionally value, and ensuring enough space and time for place-based ‘bottom-up’ processes to take effect.

***Power / Influence***

- Seek to identify a local lead health organisation (e.g., an LHD, private practice or AMS) with willingness, capacity, and ability to action a proposed health service proposal
- This lead organisation will need to have the power to alter policies or practice where appropriate to facilitate a health service innovation, but also be willing to work with community
- Identify local organisations or individuals with resources to support health service efforts with complementary resources (e.g., housing, or rental support from local council, financial or in-kind contributions from other organisations). These organisations should also be willing to work collaboratively and have power to alter policies or practice where appropriate
- Seek to structurally counter power imbalances by formalising self-determination and bottom-up decision-making in governance processes, and ensure marginalised groups and individuals are represented at upper levels of accountability and power
- Consider contributing funding to overcome imbalances in financial power. For example, if a smaller community organisation develops and is willing to deliver an innovative solution, formally acknowledge and support that group with funds that will likely protect their idea or

efforts from being duplicated by a more financially powerful party. If funds are not available, consider leveraging the funds of that more powerful party as a named funder, so that mutual interests are maintained

- Investigate whether traditional structures at a state level could be leveraged to complement collaborative approaches, such as following the Collaborative Care approach to support local communities to develop local proposals, before connecting these proposals to traditional requests for funding.

***Knowledge / Expertise***

- Seek to identify local individuals or groups familiar with the political history, relationships, and resources within and beyond the community
- Prioritise and invest in consulting with community, whether through traditional data collection (e.g., surveys, asset mapping) or community engagement methods (e.g., shared meals, informal coffee meetings and formal meetings)
- Seek to support community health service literacy to codesign heath solutions
- Source local or external subject matter or technical expertise to address identified needs (e.g., financial advice to redesign funding, technological advice to develop technological solutions, communications advice to develop public health messaging, health service campaigns or communication with community, operational advice to develop healthcare innovations, and evaluation advice to develop and embed evaluation at the outset of a collaboration)
- Facilitate linkages to training for collaborators in safe and appropriate engagement with First Nations communities. Prioritise locally designed training courses where available, or investigate the co-design of new training courses
- Proactively establish safe communication channels for First Nations participants, including establishing escalation mechanisms, such as to the Aboriginal Health and Medical Research Council (AH&MRC) of NSW, for consultation and support at a state level where required
- Seek to leverage existing efforts in NSW to support integration of collaborative innovations as ‘business-as-usual’ across the state, particularly as multiple collaboratives may develop in the remit of a particular PHN or LHD.

# Background

## Healthcare Challenges

Due to difficulty attracting and retaining General Practitioners (GPs) in rural, regional, and remote Australia and the impending retirement of the current medical workforce, it is projected that as many as 41 towns in the Western New South Wales (NSW) region alone face imminent primary healthcare collapse, with no GP in their community, by 2029[2]. Primary care challenges impact NSW Health as regional, rural and remote GPs often serve as the visiting medical officer in NSW Health Hospitals, and there can be increased emergency department presentations and flow-on effects in aged care when there is inadequate primary care in a NSW community. The need to effectively address primary care 'market failure' in regional, rural, and remote NSW is thus a highly complex and pressing concern for the state of NSW.

## Existing Solutions

To equip the state to respond effectively to the potential for primary care 'market failure' at multiple and varied sites within the next few years, it may be useful to examine and learn from existing responses to primary care market failure in NSW. One such process is a place-based planning approach$_2$, of which a prominent example in NSW is the Collaborative Care Program. The Collaborative Care Program was piloted by the NSW Rural Doctors Network (RDN) and emerged from a longstanding town-based planning approach[3,4]. The Program works with local health professionals and communities to create access to primary healthcare that fits their needs.

From 2021-2023, the RDN was Commonwealth-funded to "carry out five proof-of-concept pilots" of Collaborative Care in NSW via the Innovative Models of Care (IMOC) grant scheme, which aims to trial, learn from or evaluate new multidisciplinary primary care models in rural and remote Australian communities[5]. The potential scalability of the approach used by the Collaborative Care Program is yet to be determined. The RDN describes Collaborative Care Program as involving the following approach[4]:

1. **Investigate needs:** What do we know about the primary health care needs in these communities?
2. **Prioritise needs:** Which of these needs should we tackle first?
3. **Co-design solutions:** Decide together how services could be made easier for local communities to access.
4. **Implement solutions:** Put the plan into practice and make sure communities know what to expect.
5. **Reflect & learn:** Look at what is working well and where improvements can still be made.

[2] For the purpose of this Scalability Assessment, we define place-based planning as an approach that takes into account the specific context of a geographic location through collaboration and shared decision making with the local community.

The RDN's visual representation of their Collaborative Care Program is supplied in Figure 1.

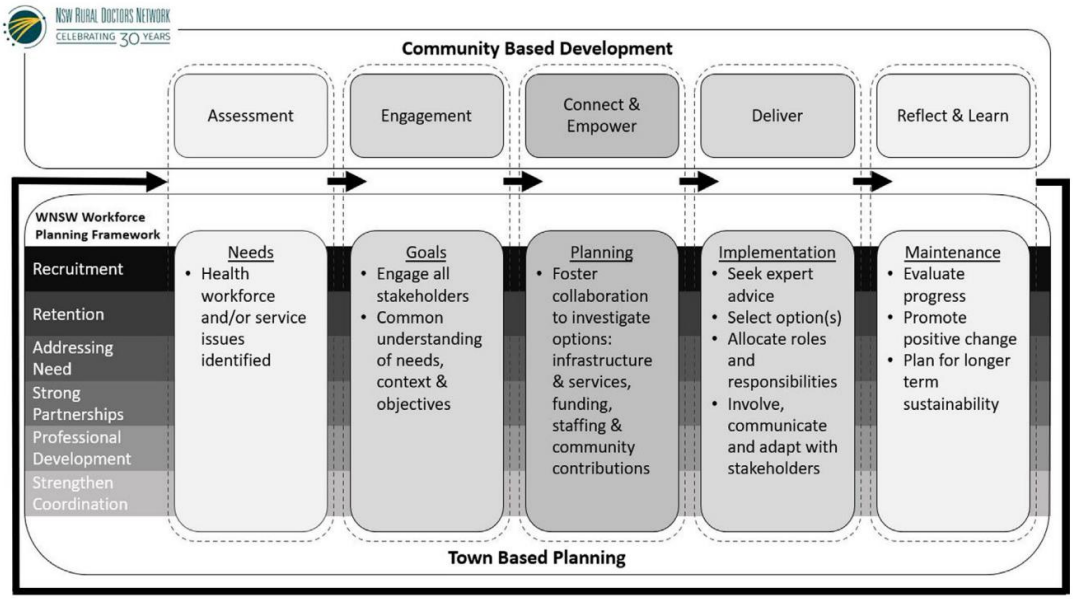


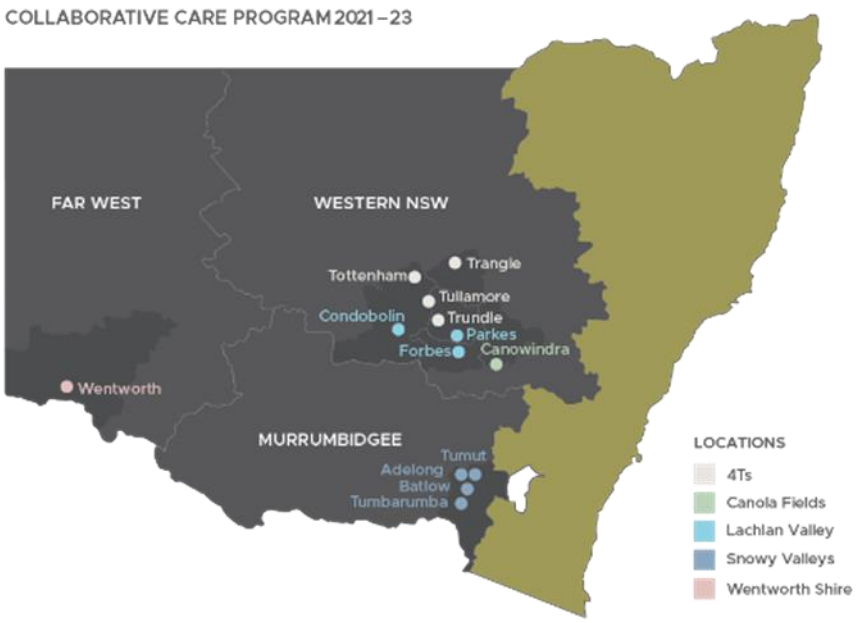

**Figure 1. RDN's published description of the Collaborative Care Program[3].**

The Collaborative Care Program can therefore be described as an ***approach*** that can be put in place to support communities to develop solutions to local primary care challenges, rather than a prescriptive ***model of care*** that can be implemented similarly in different communities. A critical element of the approach is its in-built flexibility, which enables intervention at the various stages of development of site-specific models of care; from the initial planning stage, through to a model being implemented as 'business-as-usual' in a community. This flexibility ensures the approach can support communities at different stages of readiness for a model.

The 2021-2023 IMOC grant funded the trial of a Collaborative Care Program that used a Collaborative Care approach to support five models of care, each at different stages of maturity and development:

(1) a Local Health District (LHD)-led central administration model of care (the '4Ts' model),
(2) a GP-led Deliberate Team-based Care (DTBC) model (Canola Fields)
(3) an Aboriginal Community Controlled Health (ACCHO)-led shared GP model (Wentworth Shire), and
(4) the development of new models of care at two additional geographical sites (Lachlan Valley and Snowy Valleys).

Information about each model is summarised in **Figure 2**.




| | New South Wales, Australia<br>"Collaborative Care Program/Approach": a community-centred approach to addressing the primary health care challenges in remote and rural NSW. | | | | |
|---|---|---|---|---|---|
| **"Project": Site-specific primary care model under trial/ development, geographically named** | **Wentworth Shire** | **4Ts** | **Canola Fields** | **Lachlan Valley** | **Snowy Valleys** |
| **"Site": Geographical location** |  **Far Western NSW:** Wentworth, Dareton, Buronga and Gol Gol |  **Western NSW:** Tottenham, Tullamore, Trangie, and Trundle |  **Western NSW:** Canowindra and its surrounding towns |  **Western NSW:** Condobolin, Forbes, and Parkes |  Towns of the **Snowy Valleys Local Government Area/ Murrumbidgee area:** Tumut, Tumbarumba, Batlow and Adelong |
| Project/ model description | ACCHO-led (Coomealla), shared multidisciplinary primary care clinic, salaried utilising 19(2) and 19(5) exemptions. | An LHD-led (WNSWLHD), central administration, single-employer mechanism to deliver primary care via networked primary care clinics and telehealth services across four communities, utilising 19(2) exemption. | A GP-led (Dr Ros Bullock) deliberate, multidisciplinary team-based care (DTBC, a variation of integrated care) model for chronic disease management. | Regional primary health workforce needs assessment and co-design of a 5-year health workforce strategy / development of a shared GP model of care across the region. | Co-design of a shared allied health/medical appointment model for chronic disease management (diabetes). |
| Maturity | Model under trial, responding to market failure in 2020 | Model under trial, developed in response to market failure in 2018 using methods that pre-dated the Collaborative Care approach | Model evaluation for a model trialled since 2018 | Model under development | Model under development |

**Figure 2. Definitions and descriptions of the Collaborative Care approach and the five funded models. Photo and map source: RDN[4].**

Although no formal evaluations of effectiveness of these models of care have been published, anecdotal evidence suggests that they are addressing at least some of the primary care challenges in regional, rural, and remote NSW. Given this, and the pressing nature of primary healthcare challenges in NSW, the RHD MoH commissioned the Sax Institute to undertake a scalability assessment of the Collaborative Care approach.

Understanding how to successfully scale Collaborative Care approaches supports RHD MoH to meet Priority 5 of the NSW Regional Health Strategic Plan 2022-2032 Priority Framework, '*Expand integration of primary, community and hospital care*, includes a target to '*Double the number of collaborative care models across regional local health districts by trialling and expanding on effective models*.' It also supports recommendations 10 and 43 from the NSW MoH Response to the Regional Health Inquiry:

- Recommendation 10 is for the NSW Government to work with the Federal Government to develop and trial models that support communities where existing rural health services do not meet community needs, and
- Recommendation 43 is for the NSW Government to provide relevant data to inform needs assessment and implementation of Local Health Plans.

## Aims

This scalability assessment aims to:

1. Understand how the Collaborative Care approach works and the factors that support its success
2. Understand the role of RHD MoH in scaling the approach.

# Methods

The following section provides a detailed outline of the methods for the scalability assessment, finalised in close consultation with members of the RHD MoH.

## Rapid thematic review of the literature

A rapid thematic review was conducted to examine models developed from place-based planning[3] in Australia and internationally. The review included searching national and international peer-reviewed publications and grey literature for descriptions and evaluations of models developed from place-based planning in rural or regional locations. The review sought to answer the following research questions:

1. What models developed from place-based planning have been implemented in NSW, Australia and internationally, and what are their characteristics (i.e., context, scale, coverage)?
2. What were the factors (including policies, policy frameworks, programs, process factors and funding mechanisms) that became barriers or enablers to the sustainability, feasibility, acceptability, equity, scalability, and cost of these models?

PubMed and Scopus databases were systematically searched in June 2023. Titles, abstracts, and keywords within the electronic databases were searched. Three related strategies were used to search the literature:

1. A search for place-based planning, or models addressing chronic conditions in rural areas which were developed from place-based planning, covering the past five years (2018-2022)
2. An equivalent search for the five years prior to that (2013-2017), which focused only on Australia
3. A search covering 2017 – 2023 focused on Rural Area Community Controlled Health Organisations.

Records identified through database and grey literature searches were collated and screened using the Covidence reference management software[6]. All duplicates were removed. To select the relevant papers, the eligibility criteria presented below was used.

*Inclusion Criteria*

1. Descriptions and evaluations of the approach, or models developed from the approach, in rural and regional locations
2. Focused on the approach or models of primary care services developed from the approach
3. Reported on mechanisms that enabled the approach, or models developed from the approach
4. Countries and jurisdictions within scope were: Australia, New Zealand, Canada, United Kingdom

[3] For the purpose of the review, place-based planning was defined as an approach that takes into account the specific context of a geographic location through collaboration and shared decision making with the local community.

5. Peer reviewed and grey literature using a range of methodologies (e.g., quantitative, qualitative, mixed methods). Descriptive reports (e.g., grey literature evaluation reports)
6. Papers published in the last five years (though exceptions were made for papers known to be of particularly high relevance)
7. English-language publications only.

*Exclusion Criteria*

1. Papers describing a model which focussed on prevention or promotion
2. Papers describing a model which focussed on integrated care without place-based planning
3. Protocol papers
4. Expert opinions and book chapters
5. Specific sub-populations e.g., veterans
6. Review papers.

Further information on the search strategy can be found in Appendix A.

Data extraction was initially trialled with three papers, and subsequently involved iterative revisions to ensure the data appropriately addressed the project needs. Papers for extraction were split among three team members and frequent discussions were shared to check extraction approaches as a quality assurance measure. When extracting, the relevant information to answer the research questions was taken mostly from the results sections of individual studies, particularly when identifying enablers and barriers. However, the background and discussion sections were also at times used as they contained relevant information required for our review.

Five criteria, defined in Table 2, were used to synthesise the findings from the literature review: feasibility, acceptability, sustainability and scalability, and cost considerations. The descriptive findings relating to geographic characteristics, types of models used, and target population demographics were summarised (see Appendix B). Similarly, findings regarding the enablers and barriers for feasibility, acceptability, sustainability and scalability, and cost considerations relating to the approach or models developed from the approach, were thematically analysed[7]. Equity considerations were also considered in the context of each of the five criteria. Notably, the enablers and barriers were synthesised to be relevant to the approach and its scalability, rather than the individual models and their success factors to address the research aims. Cross-cutting high-level themes and their relevant subthemes were summarised. To aid with transparency in the findings, a table mapping the records which reported enablers and/or barriers for the five criteria in line with the themes, was developed.

**Table 2. Definition of the five criteria that guided the assessment of the included records[8].**

| Criteria | Definition |
|---|---|
| Feasibility | The extent to which a new treatment, or an innovation, can be successfully used or carried out within a given agency or setting. |
| Acceptability | The perception among implementation stakeholders that a given treatment, service, practice, or innovation is agreeable, palatable, or satisfactory. Acceptability should be assessed based on the stakeholder's knowledge of or direct experience with various dimensions of the treatment to be implemented, such as its content, complexity, or comfort. |

| | |
|---|---|
| Sustainability | The extent to which a newly implemented treatment is maintained or institutionalized within a service setting's ongoing, stable operations. |
| Scalability | The ability of a health innovation to be expanded under real-world conditions to reach a greater proportion of the eligible population, or be replicated, transferred, or sustained. |
| Cost | (Incremental or implementation cost) the cost impact of an implementation effort. |

## Stakeholder consultations

Individual or group consultations were undertaken with three stakeholder groups:

1. Individuals involved in the development of the Collaborative Care Program
2. Individuals involved in the development of one of the five specific models of care
3. Individuals with knowledge of the NSW Health system and regional NSW context.

RDN made an initial approach to potential interview participants from the first and second stakeholder groups (except for First Nations participants) to ask them if they would be willing to participate in a voluntary interview. The RHD MoH team approached potential participants from the third stakeholder group. Potential First Nations participants were approached by the Sax Institute's Aboriginal Senior Advisor. Potential participants who agreed and consented to being interviewed were invited by email to participate in a 60-minute interview via Microsoft Teams videoconferencing facility. Participants were offered the option of participating alone or with another member of their organisation. Interviews were conducted between the 31st of August 2023 until the 18th of October 2023. Interviews were recorded via Microsoft Teams. Interviewees were given options not to be recorded, to speak "off the record", for access to recordings to be restricted to the interviewer, and for varying degrees of detail to be communicated. First Nations interviewees were jointly interviewed by a project team member and the Sax Institute Aboriginal Senior Advisor to ensure cultural safety and appropriateness. Discussion guides detailing the questions asked of interview participants can be found in Appendix C and Appendix D.

A thematic analysis of interview data was conducted to identify common themes and learnings.

### Synthesis of findings from the literature and stakeholder consultations

The ExpandNet/World Health Organization's (WHO) published framework, which outlines a process for scaling up, was used to organise and align emerging themes from both the review and the consultations.

### Reporting Considerations

Given the potential to identify individuals, the RHD MoH confirmed that verbatim quotations from stakeholders were not appropriate for inclusion in this report. Rather, paraphrasing has been used to represent the views and recommendations of participants.

This report refers to ‘collaborators’, ‘facilitators’ and ‘coordinators’. These are defined as:

1. **Collaborator**: all relevant local health and/or community stakeholders who could be involved in a collaboration because they have a stake in the outcome
2. **Facilitator**: the organisation or individual(s) responsible for facilitating the establishment of a new collaboration, or strengthening an existing collaboration
3. **Coordinator**: an individual or organisation responsible for the ongoing coordination of the collaboration.

# Findings

## Reviewed studies

As summarised in Figure 3, a total of 17 studies were reviewed. Of the 17 papers included for review, the majority (n=14) described models located in Australia, three models were implemented in Canada, and one in Spain. Eleven records described healthcare or place-based models, programs, or approaches (model, n=8; program, n=2; approach, n=1) involving First Nations populations. Some comprised multi-site models and the papers describing them reported findings from rural, regional, and urban settings (n=4). The demography of the towns in which the models were set was diverse and not always described. Appendix B summarises the findings of the review, specifically, the context, populations of interest and models developed from the approach.

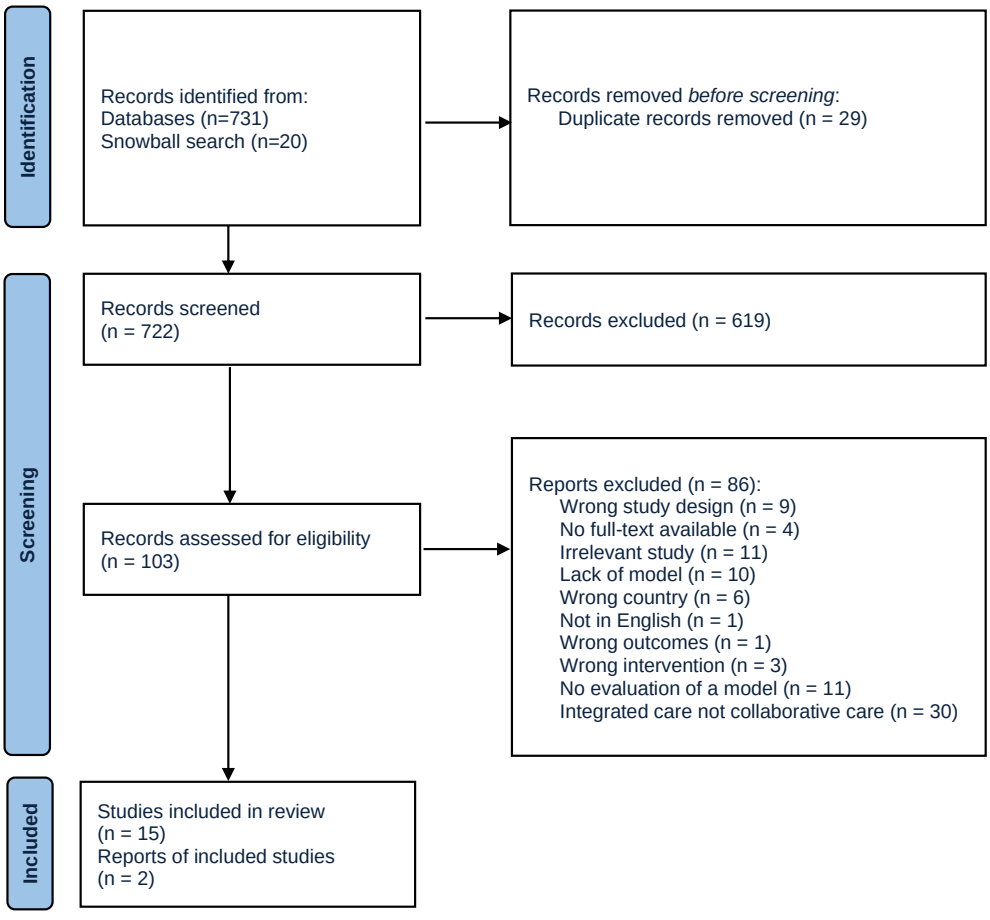



**Figure 3. PRISMA diagram.**

## Stakeholder sample

A total of 22 stakeholder consultations were completed. Given the small size of the organisation's participants represented, and the potential for identification, no further information is provided about the characteristics of the participants in the consultations.

## Synthesis of review and stakeholder consultations

The four distinct themes to emerge from the thematic analysis were:1) Stakes / Interests; 2) Trust / Time; 3) Power / Influence; and 4) Knowledge / Expertise. The below section provides further detail on these themes. A high-level summary is provided in Table 3.

### Theme 1: Stakes / Interests

The first theme, *"Stakes / Interests"*, was inductively derived from four subthemes: (1A) Ensure a multidisciplinary, whole-of-system, coordinated approach (Invite everyone to collaborate); (1B) Identify and articulate mutual interests (What is the benefit of collaborating?); (1C) Declare and manage competing and conflicting interests (What other agendas could put collaboration at risk?); and (1D) Appoint an impartial intermediary to facilitate the collaboration (Who would treat everyone equally?).

#### *Subtheme 1A: Ensure a multidisciplinary, whole-of-system, coordinated approach (Invite everyone to collaborate)*

An inclusive, whole-of-system approach that ensures collective responsibility of all relevant stakeholders was a common enabler throughout different stages of model development (i.e., in developing strategic milestones, setting action plans) or deployment (co-driving model delivery with community, resource mobilisation under the model). Partnership investment and success involved examples such as taking a 'whole-of-government' approach to funding, implementing targeted 'whole-of-community' case management, engaging in multi-sector collaboration to mobilise various resources and operate on multiple levels, and having community as co-drivers from the beginning of model/project deployment[9–18]. Descriptions of an inclusive approach included sectors/stakeholders such as: industry, government, post-secondary institutions, philanthropic foundations, not for profits, existing health professionals, community-controlled sectors, community volunteers, informal carers, and family[12,18]. Similarly, examples of enablers for establishing and maintaining model delivery included: frequent information exchange avenues to ensure coordinated care, having clear clinical governance procedures (i.e., policies, procedures and protocols, quality and safety mechanisms), and using a single-employer model for health medical service delivery[9,19–21]. Coordinated timing of funding with national and state policies, and supplementing funding with local industry also facilitated model success[12,18].

The reviewed evidence was corroborated by stakeholder reports that a successful collaboration will integrate all sectors of society affected by or influential to local healthcare innovation. It was considered essential that stakeholders had some interest or stake in outcomes for the community and its health if they were to be willing to participate in a collaboration in-kind.

The potential impacts of relevant collaborators not being identified and invited were: (1) excluded collaborators perceiving reputational loss or feeling less valued and willing to participate in the collaboration, and (2) included collaborators feeling the collaboration was less effective without them. This was because those with a stake or interest in healthcare or in the community also had the most influence to improve it (see Theme 3, Subtheme 3A and 3B).

### *Subtheme 1B: Identify and articulate mutual interests (What is the benefit of collaborating?)*

The reviewed evidence indicated that fostering a shared vision and purpose facilitated cooperation for model development and/or delivery despite histories of competition[9,12,14,19,20]. Collaboration was enabled by the ability to effectively articulate and gain agreement on a clear action plan, including communication/reporting procedures and what partners could accomplish working inter- and intra-organisationally[9,14,17,18]. This was corroborated by stakeholders with direct experience of the Collaborative Care Program who highlighted the importance of acknowledging that there will be differences and commonalities between the interests of facilitators, collaborators and coordinators when taking a place-based planning approach. These interests can be further shared with or differentiated from the specific interests of other local parties, such as local governments, non-government organisations (NGOs), First Nations peoples, community groups and organisations, and private businesses.

Common interests may be foundational to a willingness to collaborate at all, particularly given the in-kind requirements of collaborators. Failure to acknowledge, identify and communicate each party's stakes/interests could result in:

1. Lack of clarity as to the purpose and objectives of forming a collaboration.
2. Inadequate sharing of useful resources or knowledge.

### *Subtheme 1C: Declare and manage competing and conflicting interests (What other agendas could put collaboration at risk?)*

This sub-theme did not emerge in the reviewed literature. Stakeholders experienced the need to uncover competing or conflicting interests. They advised that any competing or conflicting interests did, and would, have a significant ongoing impact on the collaboration, regardless of whether they were formally recognised or acknowledged.

1. **Competing interests** could be both historical and current. For example, two or more towns may have historically competed for resources in a subregion, or two or more services may currently be competing for clientele. Inadequate recognition and management of these competing interests could prevent the establishment of the trust required as a foundation for effective collaboration, and required proactive management. Historical distrust is explored in Theme 2 (Subtheme 2A).
2. **Conflicts of interest** need to be declared and managed transparently and fairly from the outset to prevent the eventual breakdown of trust when these conflicting interests inevitably become apparent to all parties. Breakdowns in trust are explored in Theme 2 (Subtheme 2C).

Therefore, both Subtheme 1B and 1C require collaborators, facilitators and coordinators to be transparent regarding their own specific needs, objectives, and values, and to then consider how these agendas may impact the broader aims of the collaboration, whether positive (mutual) or negative if undeclared (conflicting and competing).

### *Subtheme 1D: Appoint an impartial intermediary to coordinate the collaboration (Who would treat everyone equally?)*

This sub-theme did not emerge in the reviewed literature. Stakeholders suggested that ongoing coordination of the collaboration should be the responsibility of a coordinator who can act as an impartial intermediary, to

avoid fundamentally establishing a conflict between the interests of an employing organisation and the interests of the community. For example, when the coordinator role was rotated between organisations, interview participants observed that the objectives of the collaboration could become aligned with that individual's employing organisation, even when that organisation may view themselves as being an impartial collaborator.

Stakeholders reflected that a local community member from a sector adjacent to health, such as education, without preconceptions or prior history of organisational distrust, may be better situated to coordinate to ensure a good outcome for their community, and may be better able to successfully engage the perspectives of stakeholders both within and outside the health sector, such as local government and First Nations or community groups.

Where the recruitment of a suitably impartial coordinator from the local community was not possible, stakeholders highlighted the need for self-reflection, honesty and transparency regarding the organisation or individual's motives for initiating and taking on responsibility for coordination of the collaboration, and how much they do, or do not, align with the community's interests. For example, coordinators could declare and transparently communicate their own individual or organisational objectives or funding priorities, and how the objectives of place-based planning align with their own organisational interests, as these would inevitably become apparent to collaborators even if they were not declared.

Facilitating organisations could also support development of recruitment processes to protect the impartiality of the coordinator. Such as developing templates for recruitment materials that specify that community engagement skills, local leadership, and the ability to take an 'arms-length' approach to coordination of the collaboration as essential requirements for the role, and health system experience as non-essential. Should the coordinator not have health system experience, however, the facilitator should consider how they might build the coordinators health system literacy. The facilitator could also support the development of strong governance processes and tools, such as draft Terms of Reference, that emphasise the need for transparency and impartiality.

## Theme 2: Trust / Time

The second theme, *"Trust / Time"*, was based on three subthemes: (2A) Adjust project timeline to accommodate historical trust and distrust between collaborators, facilitators, and communities (How ready are we for collaboration?); (2B) Facilitate the establishment of trust through transparent communication and consistent action over time (Always say what you will do and do what you have said); and (2C) Prevent or manage the rapid breakdown of trust (How can we prevent or quickly resolve problems?).

### *Subtheme 2A: Adjust project timeline to accommodate historical trust and distrust between collaborators, facilitators, and communities (How ready are we for collaboration?)*

The second theme was the concept of trust over time. Trust was essential to establish and progress an initiative. However, participants described a spectrum of historical trust between collaborators. Some described experiencing the benefits of (1) strong, long-established trust, with effective and rapid collaboration outcomes as a result, and (2) trust being conferred to newcomers as a trusted third party, with similarly effective outcomes when there was inadequate time to develop historical trust. Others described (3) acting in good faith when there was inadequate opportunity to establish historical trust among parties encountering each other for the first time, and others acknowledged (4) historical distrust, or (5) the rapid breakdown of trust during the collaboration (particularly through undeclared conflicts of interest as explored in Theme 1, Subtheme 1C).

This spectrum of trust can exist not only between collaborators, but between collaborating organisations, local communities, coordinators and facilitators. In addition to historical distrust between towns, there may be a sense of historical distrust between a facilitating organisation and a local community, between the coordinator and collaborators, between the collaborators and communities, and between governments and First Nations peoples. For example, the reviewed literature indicated that building trust with First Nations people over time was enabling due to past negative experiences with health services[19]. Inversely, negative patient perceptions

and past experiences of health services, and community resistance due to complex social, political and cultural environments involving First Nations populations, were a barrier[16,22].

Likewise, organisations or individuals coordinating the collaboration needed a degree of trust from collaborators; stakeholders described coordinators with a long history and existing respect in the local community as being an enabler of successful collaboration, but the high turnover of the coordinator roles, and the challenge of having to re-establish trust, as a barrier.

Histories of trust could be leveraged, with collaborators who had a history of successful collaboration working together readily on new initiatives, and individuals who were already well-respected or trusted in the community facilitating collaborations easily. Leveraging pre-existing histories of trust was therefore an asset to collaboration, as time required to build trust was reduced. This was corroborated by the reviewed evidence: having a local champion or a key coordinator leading the model, service staff who recognised the local community needs and preferences, or someone trusted/known to the community being employed or accessible to service staff members were found to enable model delivery[9,10,15,20,23,24]. Studies elaborated that this relational process was one that required time and the development of respectful partnerships to build trust; particularly when working with First Nations people[10,15].

### *Subtheme 2B: Facilitate the establishment of trust through transparent communication and consistent action over time (Always say what you will do, and do what you have said)*

Although limited project timelines are a consideration for the establishment of the trust required for effective collaboration, the passage of time was insufficient to establish trust, as evidenced by longstanding histories of distrust. Stakeholders note that consistent, integrous communication and action over time was key to establishing trust. In the published literature, the emphasis was on communication of model delivery efforts with the wider community, including raising awareness of the service delivery model at the community level to other health services and organisations[10]; and ensuring extensive community consultation to develop awareness and trusting relationships[18,19]. Stakeholders similarly described national recognition of local efforts as a valuable outcome of the program, but also experienced the importance of consistent communication and follow-up between collaborators and facilitators. For example, when there may be historical distrust between collaborators and facilitators, meeting agendas and minutes could detail who was invited and who attended and could be distributed to all invitees and attendees irrespective of attendance.

### *Subtheme 2C: Prevent or manage the rapid breakdown of trust (How can we prevent or quickly resolve problems?)*

This sub-theme was not evident in the reviewed literature. Where a project timeline is inadequate to develop a long history of trust, and collaborators were therefore primarily sharing knowledge and resources in good faith, trust was precarious and rapidly broken. Therefore, a proactive, preventative approach was recommended, as well as the establishment of processes to quickly redress broken trust should it occur.

## Theme 3: Power / Influence

The third subtheme concerning *"Power / Influence"* was established from three subthemes: (3A) Identify a committed local health service with sufficient capacity and flexibility for innovation (Who makes decisions about local health services?); (3B) Identify complementary local resources and leadership (Who makes decisions about the resources that could help the health service?); and (3C) Structurally counter power imbalances between collaborators, facilitators, coordinators and communities (How can we ensure everyone contributes to decisions?).

### *Subtheme 3A: Identify a committed local health service with sufficient capacity and flexibility for innovation (Who makes decisions about local health services?)*

In the reviewed literature, utilising existing community or health service resources and capabilities was commonly reported as an enabler for model delivery. This included joining resources and capabilities to better address rural health workforce issues, co-location of services to better understand involved stakeholders'

services and facilitate informal networks, integrating local community employment into clinical and non-clinical services, and pooling limited resources to reduce duplication and ensure continuity of care [3,14,16,18–20,23,24]. Additionally, building on the existing clinical business, administrative and Information Technology (IT) systems for the integration of the model into day-to-day services supported the health workforce to effectively maintain clinics[11,19–21]. In one instance, a barrier to model delivery was the absence of inducting the existing health service staff into the new model[23].

Another enabler included adapting and improving the model over time, with flexibility in its delivery in relation to how overall goals were implemented at regional and local levels, with appropriate progress monitoring[13,14,24]. Reducing the need for patients to travel for health services by means of mobile, drive-in-drive-out, fly-in-fly-out, or virtual health services was considered essential to providing care given the rural/remote contexts[15,22]. Expanding the services delivered (e.g., to include dental and routine pathology services) and considering social supports such as home care services or social housing assistance also helped to meet the needs of the population[10,19,23]. There were some instances where staff found adapting to the norms of overseas-trained or locum doctors challenging[12,23]. Therefore, successful healthcare innovation was a complex process that required agility, flexibility and capacity from local health services and wider healthcare systems.

Insufficient capacity was commonly reported as a barrier to health service delivery, particularly relating to staffing and resourcing; in some instances patient engagement was negatively impacted by a lack of capacity[12,15,19,22,24]. Operational, technical and logistical issues and inconsistencies (i.e., absence of or variation in electronic medical records between sites, logistical issues with running mobile clinics, inexperienced or underqualified staff, high staff turnover) were also barriers to coordinating care across the continuum and were not conducive to delivering care for chronic disease[10,14,19,22,24]. Considerations of upstream policy and funding decisions and how they could complement model resourcing particularly facilitated scalability[10,20,22].

Financial concerns were also often significant barriers to model development and delivery. Insufficient funding beyond the initial establishment phase and lack of long-term financial commitment to the collaborative approach was a commonly reported barrier[10,12,15,17,20,23,24]. Additionally, the ability to pay for ongoing services required for chronic conditions was a challenge for patients[22]. To emphasise the importance of considering the sustainability of the model/project, one study reported that despite initial success of the model/project, communities later faced similar challenges that they initially had prior to model implementation[12]. In line with this theme, the Australian Department of Health report summarising knowledge from across 118 sites recommended the need for clearer links between operational plans, models of care and project reinvestment[25].

As there were cases of unsuitable funding arrangements for small health services, funding redesign was suggested. This involved pooling funds at the sub-regional level by using revenues from clinical service delivery together with other relevant programs[25]. Removal of cost barriers for medications for chronic conditions and generally having care providers remove or minimise out-of-pocket expenses (i.e., through charging fees equal to government subsidies, or integrating additional health services to obtain additional sources of income for services), was enabling for patients[22,23].

Stakeholders reported that inflexibility in state-determined policies could sometimes be a hindrance to the development of local solutions. For example, local ambulance staff and facilities being available to provide patient intubation when emergency nurses could not, but state-determined policies not readily supporting this change.

Although collaborators may have a stake or interest in health or in a community, to be effective participants in place-based planning they should also have relevant influence in relation to health or the community to effect change, and to ensure that decisions made through the collaboration are actionable rather than theoretical. Delivery of an innovative healthcare model in a town required the commitment of a local health service with sufficient capacity and flexibility to deliver the innovative healthcare model.

### *Subtheme 3B: Identify complementary local resources and leadership (Who makes decisions about the resources that could help the health service?)*

The literature identified enablers at the community level, including the importance of having committed local leadership, local government playing a key role in supporting the model (i.e., assisting with workforce recruitment and retention), and having support from local businesses/organisations to consider the town's future prosperity[12,18,20,21]. Similarly, flexible financing arrangements for the model was an enabler[10,12,14]. These included enhanced flexibility of government funding and having capacity to reallocate funds, supplementing funding through local industry, and engaging community assets and capacities[10,12,14].

Stakeholders described how other community organisations could contribute complementary resources to enable a collaborative approach, for example, the local council providing housing for healthcare workers, or facilities which could be used as healthcare workspaces. Other examples included local businesses providing funding, local communities supporting community-based initiatives by contributing care packages for healthcare workers, or First Nations groups taking ownership of public health messaging in schools.

### *Subtheme 3C: Structurally counter power imbalances between collaborators, facilitators, coordinators and communities (How can we ensure everyone contributes to decisions?).*

This sub-theme did not emerge in the reviewed literature. Stakeholders noted that there will be meaningful variation in the political wherewithal and resources of each collaborator, and that the structural governance of the collaboration should therefore be organised in a manner that enabled inclusion of all parties but should not overlook or systemically exacerbate inequities. One way power imbalances could be structurally managed could be enshrining bottom-up decision-making power for traditionally less powerful collaborators such as community working groups or First Nations participants, rather than establishing traditional top-down hierarchies with steering committee oversight by non-First Nations executives. It was noted and experienced that smaller organisations who may not be as politically experienced or well-resourced would still need support to participate effectively at executive levels, where partners with greater political experience, strength, and resources may still be able to outmanoeuvre others, particularly with undeclared competing or conflicting interests. As much as possible, governance should enable self-determination (via flexible policy, exit/dissolution options, and/or autonomous self-organisation).

## Theme 4: Knowledge / Experience

The fourth and final theme, *"Knowledge / Expertise"*, was developed from three subthemes: (4A) Recognise local knowledge of resources and needs as essential to success (Learn the route from local drivers familiar with the roads); (4B) Apply complementary technical and subject matter expertise to co-design solutions (share or source an engineer's understanding of the car); and (4C) Upskill in cultural safety and support, particularly for First Nations communities (learn how to include everyone's expertise).

### *Subtheme 4A: Recognise local knowledge of resources and needs as essential to success*

The reviewed literature corroborated that having local awareness and knowledge of the systems and processes in the community was an enabler, both for the broader implementation of the model and for day-to-day health service delivery. Similarly, engaging community perspectives in the development of the model through a co-design process and integrating targeted strategies to engage relevant populations (i.e., First Nations people) facilitated service delivery and acceptance[3,10]. Lack of community consultation during the implementation of the model[15], and staff not being introduced-to or communicating the scope of practice to local communities were barriers to the acceptability of the model[20]. Examples include failing to inform staff about staff involvement in model delivery and lack of staff consultation about telehealth implementation.

Critically, local knowledge of politics, networks and history was often held by local community members, and some organisations or stakeholders engaged in that community (e.g., university researchers) may also be able to provide unique visibility of and expertise regarding services and resources in a community, in a way that could inform the design of health services (see Theme 3, Subtheme 3A and 3B regarding the resources that

might be required). Stakeholders attested to the value of community-identified needs and health services, and inversely reflected that they could not have independently identified the needs raised by the community.

### *Subtheme 4B: Apply complementary technical and subject matter expertise to co-design solutions*

This sub-theme did not emerge in the reviewed literature. The application of externally sourced technical and subject matter expertise appeared to be a distinctive feature of the Collaborative Care approach in contrast to general place-based planning as described in the published literature. Stakeholders involved with the Collaborative Care Program recognised that community needs raised at a working group level could then be addressed with the support of subject matter experts (SME) groups with specific or technical expertise to develop solutions, such as individuals with financial, practice management or IT expertise, or First Nations community members. Health services reported that they also needed to support health service literacy in the community, as communities may not be familiar with the funding structures and governance of healthcare, and that, despite a strong understanding of the community need, a lower level of health service literacy could result in mismatched expectations of how a health service solution might operate. Therefore, knowledge of healthcare solutions and healthcare needs were often complementary, in the way drivers and engineers have necessarily complementary expertise to reach a common goal. Stakeholders, as noted in Theme 2 (Subtheme 2B), indicated a need for expertise concerning monitoring and evaluation activities to measure and demonstrate impact, and a need to obtain relevant ethical approval for such activities.

### *Subtheme 4C: Upskill in cultural safety and support, particularly for First Nations communities (Learn how to include everyone's expertise)*

The reviewed literature confirmed that integrating cultural safety and diversity considerations into health service delivery was critical for taking a strengths-based approach, particularly when working with First Nations people. Notably, the main cultural groups that were addressed in the included literature for the review were First Nations populations. Delivering cultural awareness training for all service staff was a common enabler and was seen as an invaluable contributor for being able to make a positive impact within the community[16,19,20,22,23]. In line with this, providing culturally safe and appropriate support for First Nations people, recognising the social determinants of health, and having cultural sensitivity as a priority for service delivery, were key for improving access to health services and building trust[14,15,19,22,23]. In some instances, it was difficult to ensure community awareness and cultural safety across the continuum of health service delivery, and a lack of cultural safety and consideration of the social determinants of health were barriers for acceptability of the model/project, causing patients to discharge against medical advice[16,19,22,23]. Finally, despite efforts to address cultural safety and equity concerns, the diversity of cultural contexts and geographical coverage that was required to reach vulnerable groups remained a challenge for some; inequitable funding models were one attributed factor[15,22,25].

Stakeholders reported that a key enabler of a collaboration was training in cultural safety and appropriateness, especially when engaging with local First Nations communities. Therefore, although there was a wealth of essential local knowledge and in-kind SME in a local community, there was also a need for external facilitators of collaboration to be mindful of cultural safety and appropriateness to collaborate effectively with First Nations organisations and individuals, including Aboriginal Medical Service.

**Table 3. Themes and subthemes identified from interview and review data.**

| Theme | Subtheme | Data Source | |
|---|---|---|---|
| | | Lived Experience | Published Evidence |
| 1. Stakes / Interests | **1A:** Ensure a multidisciplinary, whole-of-system, coordinated approach (Invite everyone to collaborate) | √ | √ |
| | **1B:** Identify and articulate mutual interests (What is the benefit of collaborating?) | √ | √ |
| | **1C:** Declare and manage competing and conflicting interests (What other agendas could put collaboration at risk?) | √ | - |
| | **1D:** Appoint an impartial intermediary to facilitate the collaboration (Who would treat everyone equally?) | √ | - |
| 2. Trust / Time | **2A:** Adjust project timeline to accommodate historical trust and distrust between collaborators, facilitators, and communities (How ready are we for collaboration?) | √ | √ |
| | **2B:** Facilitate the establishment of trust through transparent communication and consistent action over time (Always say what you will do and do what you have said) | √ | √ |
| | **2C:** Prevent or manage the rapid breakdown of trust (How can we prevent or quickly resolve problems?) | √ | - |
| 3. Power / Influence | **3A:** Identify a committed local health service with sufficient capacity and flexibility for innovation (Who makes decisions about local health services?) | √ | √ |
| | **3B:** Identify complementary local resources and leadership (Who makes decisions about the resources that could help the health service?) | √ | √ |
| | **3C:** Structurally counter power imbalances between collaborators, facilitators, and communities (How can we ensure everyone contributes to decisions?) | √ | - |
| 4. Knowledge / Expertise | **4A:** Recognise local knowledge of resources and needs as essential to success (Learn the route from local drivers familiar with the roads) | √ | √ |
| | **4B:** Apply complementary technical and subject matter expertise to co-design solutions (Share or source an engineer's understanding of the car) | √ | - |
| | **4C:** Upskill in cultural safety and support, particularly for First Nations communities (Learn how to include everyone's expertise) | √ | √ |

# Principal Findings & Recommendations

## How does a Collaborative Care approach work?

Individuals with direct experience of the Collaborative Care approach referred to the tangible or visible elements of the approach when asked about how the approach works. Funding, governance structures, and processes were all commonly identified as being important when implementing the approach. This scalability assessment contributes four new elements that could be just as, if not more, important for the success of the approach.

The findings of this Scalability Assessment indicate that the Collaborative Care approach functions through a complex interplay of the collaborators, facilitators, coordinators, and communities:1) Stakes/ Interests; 2) Trust/ Time; 3) Power / Influence; and 4) Knowledge / Expertise. Figure 4 visually represents how the Collaborative Care approach works, and how the identified themes relate to each other. A tree has been used to visually represent the approach, because metaphorically, the tangible elements of the approach, such as funding, processes and governance structures, are the more visible parts (i.e., the branches and the trunk of a tree). However, the branches of a tree cannot survive when “cut off” from the roots, or if “transplanted” to another location. The roots represent the less visible and intangible elements of the approach that affect everything, and that are critical for the survival of the Collaborative Care approach.

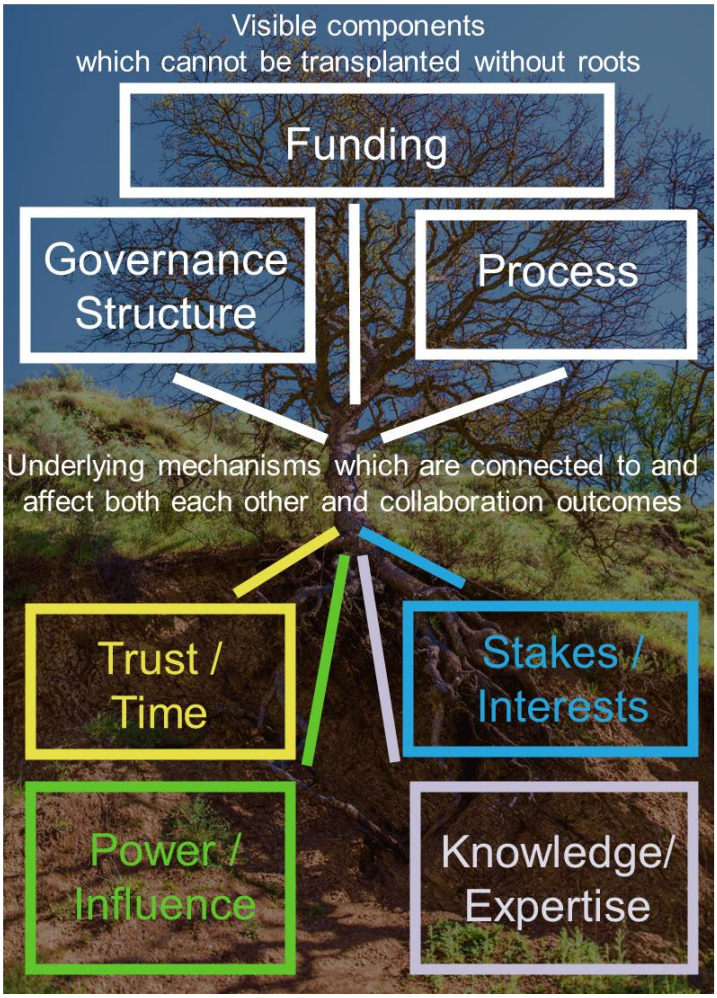



**Figure 4. A visual metaphor of the Collaborative Care approach.**

# What is the role of RHD MoH?

The findings of this report point to the RHD MoH playing the role of the facilitator in a Collaborative Care approach. This could mean facilitating the establishment of a new collaboration or stepping in to support an existing collaboration. This facilitation role will likely be more direct and resource intensive when seeking to establish new collaborations, but there may be times during the life of the collaboration when there is minimal to no involvement required and the role of the RHD MoH is to support and empower people and organisations to actively take on the role of a facilitator.

In short, the role of the facilitator is to establish strong scaffolding for the building of a Collaborative Care approach. This scaffolding can be dis-assembled, but only once the foundations for a strong and sustainable collaboration have been established. The collaboration may need attention down the track, which may require the scaffolding to be re-assembled, and the facilitator should be available and willing to step in to support should remedial action be necessary.

We offer the following recommendations, grouped by theme, to support the RHD MoH's understanding of what their role, as the facilitator of a Collaborative Care approach in NSW, could be:

***Stakes / Interests***

- When a new collaboration is being established, seek to identify and invite all relevant local health and community stakeholders (collaborators) to collaborate from the outset. Relevant collaborators could be identified via consultation with key individuals familiar with local resources, politics, and history of the local area, or via a snowball recruitment of groups or individuals who local community members believe should or could be involved because they have a personal or professional interest or stake in the outcome
- In the early establishment phase of a collaboration, clearly articulate the benefits of collaboration, encourage/foster collaborators willingness to commit in-kind time and resources, and emphasise that mutual or conflicting interests should be identified and communicated early as a foundational building block for successful collaboration
- Support the establishment of processes from the outset that allow collaborators to reflect on, formally declare and then manage, their objectives and interests in a safe and transparent manner, such as disclosure to an impartial intermediary where interests may be confidential or sensitive. These processes should be embedded in the routine operations of the collaborative so collaborators can regularly reflect on and declare any emerging interests throughout the life of the project
- Where possible, identify and support the appointment of an impartial intermediary to coordinate the collaboration (the coordinator). Specifically, someone who is not an employee or representative of the interests of any specific collaborator
- Support the development of recruitment processes for the coordinator role that emphasise the need for transparency and impartiality, and strong community engagement, leadership, and an 'arms-length' approach
- Given the importance of the coordinator role, consider not proceeding with a collaboration until a suitable appointment has been made.

***Trust / Time***

- Be aware of longstanding histories of competition between potential collaborators which could impact collaborative efforts. Inversely, there may be a long history of successful collaboration which could be leveraged. These preconditions will affect project timelines and budgets and therefore community readiness to participate.
- Allocate time for the establishment of trust when planning collaboration timelines and budgets. If there are histories of distrust in communities, we recommend a timeline of five to seven years, and no less than three years

- Manage expectations of what can be achieved in a particular timeframe with a certain amount of funding to avoid the erosion of trust in the funder when, and if, the funding comes to an end
- Appoint coordinators with established community trust, and (where possible) ensure they are not employed by one of the collaborating parties
- Maintain integrous, transparent communication from facilitators regarding procedures
- Publicly communicate, recognise and celebrate collaborators and what has been achieved (e.g. via the media)
- Ensure evaluation of outcomes and implementation is considered at the outset of a collaboration to enable robust data collection and rigorous evaluation in the future
- Where time may not allow for trust to be developed, enshrine and communicate the values of equality and collaboration in project management and governance processes. For example, Terms of Reference, policies, funding criteria, data collection processes, and recruitment criteria
- Support the establishment of trust through transparent communication and consistent action, particularly when newly introduced collaborators are working together for the first time, or when there is distrust or broken trust between collaborators, or with the facilitator
- Proactively manage breaches of trust between collaborators by “refereeing” misaligned behaviour, and use the above governance processes (e.g. Terms of Reference) as a mechanism for managing misaligned behaviour
- Consider how to achieve balance between ‘not just meeting for meeting’s sake’, something government stakeholders traditionally value, and ensuring enough space and time for place-based ‘bottom-up’ processes to take effect.

***Power / Influence***

- Seek to identify a local lead health organisation (e.g., an LHD, private practice or AMS) with willingness, capacity, and ability to action a proposed health service proposal.
- The lead organisation will need to have the power to alter policies or practice where appropriate to facilitate a health service innovation, but also be willing to work with community
- Identify local organisations or individuals with resources to support health service efforts with complementary resources (e.g., housing, or rental support from local council, financial or in-kind contributions from other organisations). These organisations should also be willing to work collaboratively and have power to alter policies or practice where appropriate
- Seek to structurally counter power imbalances by formalising self-determination and bottom-up decision-making in governance processes, and ensure marginalised groups and individuals are represented at upper levels of accountability and power
- Consider contributing funding to overcome imbalances in financial power. For example, if a smaller community organisation develops and is willing to deliver an innovative solution, formally acknowledge and support that group with funds that will likely protect their idea or efforts from being duplicated by a more financially powerful party. If funds are not available, consider leveraging the funds of that more powerful party as a named funder, so that mutual interests are maintained
- Investigate whether traditional structures at a state level could be leveraged to complement collaborative approaches, such as following the Collaborative Care approach to support local communities to develop local proposals, before connecting these proposals to traditional requests for funding.

***Knowledge / Expertise***

- Seek to identify local individuals or groups familiar with the political history, relationships, and resources within and beyond the community
- Prioritise and invest in consulting with community, whether through traditional data collection (e.g., surveys, and asset mapping) or community engagement methods (e.g., shared meals, informal coffee meetings and formal meetings)

- Seek to support community health service literacy to codesign heath solutions
- Source local or external subject matter or technical expertise to address identified needs (e.g., financial advice to redesign funding, technological advice to develop technological solutions, communications advice to develop public health messaging, health service campaigns or communication with community, operational advice to develop healthcare innovations, and evaluation advice to develop and embed evaluation at the outset of a collaboration).
- Facilitate linkages to training for collaborators in safe and appropriate engagement with First Nations communities. Prioritise locally designed training courses where available, or investigate the co-design of new training courses
- Proactively establish safe communication channels for First Nations participants, including establishing escalation mechanisms, such as to the Aboriginal Health and Medical Research Council (AH&MRC) of NSW, for consultation and support at a state level where required
- Seek to leverage existing efforts in NSW to support integration of collaborative innovations as 'business-as-usual' across the state, particularly as multiple collaboratives may develop in the remit of a particular PHN or LHD.

## Strengths & Limitations

A strength of this scalability assessment was its inclusion of both reviewed literature and consultation of stakeholder lived experience to understand the Collaborative Care approach. Stakeholder consultation contributed many novel insights that were not available in the published literature, particularly when data was collected in an ethically considerate, anonymous manner. Participants spanned all five Collaborative Care Program model sites, and a range of organisations in NSW. The interpretation of results was validated with working group stakeholders, and with an Aboriginal Senior Advisor. The results of this scalability assessment should be reviewed in tandem with evidence of the Collaborative Care Programs effectiveness, when available. However, as the focus of this scalability assessment was on scalability rather than effectiveness, the findings still provide valuable insights on how this approach works, and how it could be scaled.

## Conclusions

The findings of this scalability assessment are that RHD MoH has the potential to play a critical role in the facilitation of a collaborative care approach in regional, rural, and remote NSW. There are some functions the RHD MoH is well placed to fulfill directly, and others which it can support by delegating and empowering people and organisations locally. Fulfilling both these roles effectively requires an understanding of the complex, underlying interplay of factors required to facilitate a positive, effective collaboration, which have been surfaced through lived experience of the program during its pilot and corroborated through literature review. Further insight into some of the challenges and opportunities that may lie ahead include integrating and streamlining community engagement processes and improving culturally safe engagement with First Nations communities. These recommendations will need to be interpreted in relation to primary findings regarding the time taken to establish the trust required for effective collaboration, and the power imbalances that may need to be remedied when decision-making is expedited through traditional, rather than community-centred approaches.

# Appendices

## Appendix A. Database search strategy.

### Scopus search strategy

| Database: | Scopus |
|---|---|
| **Terms:** | ( TITLE-ABS-KEY ( "chronic disease" OR "chronic illness" OR "chronic condition" )<br>AND<br>TITLE-ABS-KEY ( "collaborative care" OR "integrated care" OR "place-based" OR pbi OR "local health planning" OR locality-based OR "locally determined" OR "community activation" OR "community mobilisation" OR "community-based planning" OR "community-based care" OR ( "health services" AND "market failure" ) OR ( "health services" AND sustainable ) OR ( "health services" AND funding ) OR "place-based health care planning" OR "rural generalist" OR "team-based care" )<br>AND<br>TITLE-ABS-KEY ( intervention* OR program* OR initiative* OR strateg* OR campaign* OR policy OR policies OR "practice model" )<br>AND<br>TITLE-ABS-KEY ( rural OR regional OR remote OR community )<br>AND PUBYEAR > 2017 )<br>OR<br>( TITLE-ABS-KEY ( "Rural Area Community Controlled Health Organisation" OR "RACCHO" )<br>OR<br>( TITLE-ABS-KEY ( rural OR remote )<br>AND<br>TITLE-ABS-KEY ( "primary care" OR "health workforce" )<br>AND<br>TITLE-ABS-KEY ( australia OR australian OR queensland OR tasmania OR victoria OR "Northern Territory" OR "New South Wales" OR “new Zealand” OR canada OR canadian OR ontario OR alberta OR "British Columbia" OR saskatchewan OR quebec OR manitoba OR "New Brunswick" OR "Northwest Territories" OR "Nova Scotia" OR nunavut OR "Prince Edward Island" OR yukon OR inuit OR "First Nations" OR aboriginal OR aborigine OR atsi ))<br>AND PUBYEAR > 2017 )<br>OR<br>( TITLE-ABS-KEY ( "chronic disease" OR "chronic illness" OR "chronic condition" )<br>AND<br>TITLE-ABS-KEY ( "collaborative care" OR "integrated care" OR "place-based" OR pbi OR "local health planning" OR locality-based OR "locally determined" OR "community activation" OR "community mobilisation" OR "community-based planning" OR "community-based care" OR ( "health services" AND "market failure" ) OR ( "health services" AND sustainable ) OR ( "health services" AND<br>funding ) OR "place-based health care planning" OR "rural generalist" )<br>AND<br>TITLE-ABS-KEY ( intervention* OR program* OR initiative* OR strateg* OR campaign* OR policy OR policies OR "practice model" ) |

| | |
|---|---|
| | AND<br>TITLE-ABS-KEY ( rural OR regional OR remote OR community )<br>AND<br>TITLE-ABS-KEY ( australia OR australian OR queensland OR tasmania OR victoria OR "Northern Territory" OR "New South Wales" OR "First Nations" OR aboriginal OR aborigine OR atsi )<br>AND PUBYEAR > 2012 AND PUBYEAR < 2018 )<br>AND ( LIMIT-TO ( SUBJAREA , "MEDI" ) OR LIMIT-TO ( SUBJAREA , "SOCI" ) OR LIMIT-TO ( SUBJAREA , "NURS" ) OR LIMIT-TO ( SUBJAREA , "HEAL" ) OR LIMIT-TO ( SUBJAREA , "BIOC" ) OR LIMIT-TO ( SUBJAREA , "PSYC" ) OR LIMIT-TO ( SUBJAREA , "PHAR" ) OR LIMIT-TO ( SUBJAREA , "MULT" ) OR LIMIT-TO ( SUBJAREA , "DECI" ) OR LIMIT-TO ( SUBJAREA , "IMMU" ) ) |
| **Date limit:** | Varied (see above) |
| **No. hits:** | 561 |

### PubMed search strategy

| **Database:** | **PubMed** |
|---|---|
| **Terms:** | ( ('chronic disease' OR 'chronic illness' OR 'chronic condition').mp<br>AND ('collaborative care' OR 'integrated care' OR 'place-based' OR PBI OR 'local health planning' OR locality-based OR 'locally determined' OR 'community activation' OR 'community mobilisation' OR 'community-based planning' OR 'community-based care' OR ('health services' AND 'market failure').mp OR ('health services' AND sustainable).mp OR ('health services' AND funding).mp OR 'place-based health care planning' OR 'rural generalist' OR 'team-based care').mp<br>AND (intervention* OR program* OR initiative* OR strateg* OR campaign* OR policy OR policies OR 'practice model').mp<br>AND (rural OR regional OR remote OR community).mp<br>AND (("2018/01/01"[Date - Publication] : "3000"[Date - Publication])) ).mp<br>OR<br>( ('Rural Area Community Controlled Health Organisation' OR 'RACCHO').mp<br>OR (Rural OR remote).mp<br>AND ('primary care' OR 'health workforce').mp<br>AND (Australia OR Australian OR Queensland OR Tasmania OR Victoria OR 'Northern Territory' OR 'New South Wales' OR New Zealand OR Canada OR Canadian OR Ontario OR Alberta OR 'British Columbia' OR Saskatchewan OR Quebec OR Manitoba OR 'New Brunswick' OR 'Northwest Territories' OR 'Nova Scotia' OR Nunavut OR 'Prince Edward Island' OR Yukon OR Inuit OR 'First Nations' OR Aboriginal OR Aborigine OR ATSI).mp<br>AND (("2018/01/01"[Date - Publication] : "3000"[Date - Publication])) ).mp )<br>OR<br>( ('chronic disease' OR 'chronic illness' OR 'chronic condition').mp<br>AND ('collaborative care' OR 'integrated care' OR 'place-based' OR PBI OR 'local health planning' OR locality-based OR 'locally determined' OR 'community activation' OR 'community mobilisation' OR 'community-based planning' OR 'community-based care' OR ('health services' AND 'market failure').mp OR ('health services' AND sustainable).mp OR ('health services' AND funding).mp OR 'place-based health care planning' OR 'rural generalist' OR 'team-based care').mp<br>AND (intervention* OR program* OR initiative* OR strateg* OR campaign* OR policy OR policies OR 'practice model').mp |

| | |
|---|---|
| | AND (rural OR regional OR remote OR community).mp<br>AND (Australia OR Australian OR Queensland OR Tasmania OR Victoria OR 'Northern Territory' OR 'New South Wales' OR 'First Nations' OR Aboriginal OR Aborigine OR ATSI).mp<br>AND (("2013/01/01"[Date - Publication] : "2017/12/31"[Date - Publication])).mp ) |
| **Date limit:** | Varied (see above) |
| **No. hits:** | 64 |

# Appendix B. Reviewed studies and findings.

**Note**: The availability of the relevant contextual data varied between sources, and therefore, affected extraction consistency.

**Key**: NR - Not reported, MMM - Modified Monash Model, NCD - Non-communicable disease.

| First author (citation) | Year of Publication | State, Country | Setting | Remoteness scale or info | Community Demographic | Model summary |
|---|---|---|---|---|---|---|
| Australian Government Department of Health and Aged Care [25] | 2021 | Australia | Primary health care services | Rural and remote areas - MMM categories 5 to 7. | 118 rural and remote sites across all Australian states. | An initiative or funding model that supports rural and remote communities in renumerating costs and improving access to bulk-billed primary health care at all times, including after hours at state or territory health services, such as public hospitals and multipurpose services (services which are not generally funded). |
| Bailie[22] | 2015 | Australia | Primary health care targeted at Indigenous populations | NR | Urban, regional and remote areas of Australia that have relatively large Indigenous populations. | Indigenous Chronic Disease Package - a National multicomponent program implemented through primary health care support organisations focused on NCD prevention and management for Australian Indigenous people. |
| Beks[10] | 2022 | VIC, Australia | Primary health care mobile clinics for Aboriginal Peoples | Aboriginal Community Controlled Health Organisation located in a small rural town in Victoria, Australia. The BBAC fixed clinic is located in a small rural town (MMM5). | NR | An Aboriginal Community-Controlled Health Organization model of primary health care mobile clinics facilitating the provision of general practitioner, nursing and allied health services. |

| First author (citation) | Year of Publication | State, Country | Setting | Remoteness scale or info | Community Demographic | Model summary |
|---|---|---|---|---|---|---|
| Blignault[19] | 2021 | NSW, Australia | Multi-site hospital-based transfer of care, linking hospital wards to community-based health and social services. | Model was developed and piloted at Campbelltown Hospital in response to the high rate of unplanned readmissions for Aboriginal patients with chronic disease and later adopted at Liverpool Hospital; both hospitals within South-Western Sydney Local Health District, which includes urban, rural and semi-rural areas. | Over a million people (roughly 12.5% of the NSW population) live within its catchment, with Aboriginal people comprising 2.1% of the population. Over a third (36.3%) of the SWSLHD Aboriginal population live in Campbelltown Local Government Area (LGA) and 18.7% live in Liverpool LGA | Multi-site hospital-based Aboriginal transfer of care model, linking hospital wards to community-based health and social services to deliver culturally appropriate care to Aboriginal Australians with chronic disease |
| deBatlle[11] | 2021 | Catalonia, Spain | Tertiary Hospital and Primary Care Centres | The study was conducted in Lleida - a large rural area of over 4300 km2, including two tertiary hospitals (University Hospital Arnau de Vilanova and University Hospital Santa Maria) and a network of 23 primary care centres spread across the whole territory, providing service to 400,000 citizens. | NR | Mobile health-enabled integrated care model for complex chronic patients. This involved a preliminary health assessment, self-management app, a digital activity tracker, a web-based platform monitored by the health care team, and an assigned case manager. |
| Drovandi [23] | 2022 | Australia | Pharmacist integration into the primary health care teams of Aboriginal community-controlled health services | The 20 urban, rural, and remote participating sites were geographically diverse across Victoria, Queensland, and the Northern Territory and recognized the diversity of Aboriginal and Torres Strait Islander peoples and models of care across Australia. | NR | Non-dispensing pharmacist integration model into primary health care teams of Aboriginal community-controlled health services to deliver patient support and education relating to chronic disease medications. |
| Gillespie[12] | 2022 | Mallacoota, VIC, Australia; Marathon, Ontario, Canada | Primary health care | Rural settings | Marathon: population of 3273, two First Nation communities.<br><br>Mallacoota: population of 1063. Median age is 58, and people aged 60+ comprise over 49% of the population. | Place-based recruitment and retention projects aimed at attracting health workforce to deliver primary health care in regional/rural towns |

| First author (citation) | Year of Publication | State, Country | Setting | Remoteness scale or info | Community Demographic | Model summary |
|---|---|---|---|---|---|---|
| Harfield[24] | 2021 | NT, Australia | Health care clinics | NR | NR | The Miwatj Leadership Model builds Indigenous health workforce capacity and capability through leadership. It spans recruiting Yolngu people into the organisation, developing Yolngu staff who wish to take up leadership roles, and appointing and supporting staff in leadership positions. The model respects traditional forms of authority and empowers the community to develop, manage, and sustain their own health. |
| Hungerford[20] | 2016 | Australia | Community-based clinic-located practice | The Nurse Practitioner (NP) Initiative enabled the implementation of 29 NP models of practice across remote, rural, urban and metropolitan locations in each of the Australian states and territories. | The demographics of grey nomads are not representative of all older Australians, with most grey nomads being white Anglo-Australians in their early to mid-60s and in heterosexual relationships (with the woman younger than the man)16. | Grey nomad and aged care nurse practitioner clinic-located model of community-based practice. Developed to address the health needs of remote populations and seasonal tourists. |
| MacLeod[13] | 2019 | British Columbia, Canada | Primary health care services | Northern BC has a population of about 289,000 in an area of approximately 650,000 km2 that covers the northern two-thirds of the province. It encompasses a total of 31 municipalities, including 6 cities of 5,000 or more residents (of which only one has a population >50,000), 14 district municipalities with towns having 2,500-5,000 residents plus their surrounding rural areas, 1 town of approximately 5,000 people, and 10 villages with 1,000-2,500 residents | The region has the lowest population health status in the province (British Columbia Ministry of Health, 2014/2018). Approximately 17 percent of the population in Northern BC or 47,200 people are Indigenous. The Indigenous peoples are diverse: there are 54 first nations, 9 tribal councils and 17 distinct linguistic groups. Overall, the population of the region is younger than that of BC as a whole, with the population of persons 65 and over growing at twice the provincial rate | The Northern Health System of Services Working Framework - depicts the reoriented healthcare system within which primary care providers (physicians and nurse practitioners) and specialist physicians work with integrated primary healthcare teams. |

| First author (citation) | Year of Publication | State, Country | Setting | Remoteness scale or info | Community Demographic | Model summary |
|---|---|---|---|---|---|---|
| Morrin[14] | 2013 | Alberta, Canada | Chronic disease management units | The model has been implemented successfully in 108 communities across Alberta. | Given differences across Alberta related to population diversity, level and nature of disparities and access challenges and gaps, the Alberta Healthy Living Program (AHLP) components have been or are being modified to meet the unique needs of diverse and vulnerable populations. The priority populations for the model include: 1) ethno-cultural populations; 2) Hutterites and low-German-speaking Mennonites living in remote rural settings; 3) Aboriginal people; 4) Francophone population; 5) people experiencing homelessness. | AHLP - an integrated community-based chronic disease management approach that supports adults with, or at risk for, chronic disease to improve their health and well-being. |
| Osborn[15] | 2022 | NSW, Australia | All health-care settings | A remote town in NSW where the closest major regional city is almost 400 km away. | A town with high (>65%) Aboriginal population. | A community school-based health service model delivering health-promotion programs designed to improve health literacy, and run visiting health services including nurses, occupational therapy, speech pathology, dieticians, and testing for sight and hearing. |
| Quilty[16] | 2019 | Katherine, NT, Australia | Hospital emergency department | Katherine is a sparsely populated region in the tropics of Northern Australia (NT), covering 337,000 square kilometres and encompassing 19 tribal nations, and defined by some of the worst indicators of both social and health disparities anywhere in Australia. | The participants comprised over 29 Indigenous tribal nations, only 15% were from communities close to the Katherine town, and 85% came from communities in more remote locations.<br>Population of town: 24,000 people. 51% Aboriginal. | The Wellness Support Pathway is set at Katherine Hospital and provides Katherine Individual Support Program: a whole-of-community, culturally appropriate case management service for frequent attenders, with threefold aims to reduce re-presentations, address social determinants of health, and improve health care utilisation in a community with a large Indigenous population. |

| First author (citation) | Year of Publication | State, Country | Setting | Remoteness scale or info | Community Demographic | Model summary |
|---|---|---|---|---|---|---|
| Ramsden[17] | 2019 | NSW, Australia | Primary health care | The Western NSW region covers a total area of 433,379 square kilometres. The total population of the region is estimated to be more than 313,600 people. More than a third of the Western NSW region's local government areas are classified as remote or very remote under the MMM. | | Western NSW Primary Health Workforce Partnership Model and Primary Health Workforce Planning Framework developed by five organisations securing commitment for executing a collaborative action plan aiming to build a sustainable primary health workforce, and monitoring its implementation. |
| Ramsden[9] | 2021 | NSW, Australia | Primary health care and hospital settings | The 4Ts is one of 5 subregions being supported as part of the project comprising four small rural and remote communities: Tottenham, Trundle, Tullamore and Trangie in western NSW. The area covered by the western NSW LHD is one of the largest in NSW covering 246 676 km, serving approximately 276,000 people and containing some of the most vulnerable population in NSW and Australia. | Four towns of Tottenham, Trundle, Tullamore and Trangie within the Western NSW LHD, which have populations of 451, 335, 369 and 1,188 people respectively according to census data. Aboriginal and Torres Strait Islander people account for 9.3%, 8.6%, 7.3% and 21% of the populations respectively. Males constitute 50.1%, 51.6%, 50.1% and 52.3% of the populations respectively. The respective median ages are 52, 50, 50 and 45. | 4Ts model: a place-based approach was used to co-design a model with community with coordination across providers, disciplines and sectors. It was a single-employer model where the state-funded LHDs became involved in the provision of primary health care workforce and services. |
| Reeve [18] | 2015 | Fitzroy Valley, WA, Australia | Primary health care targeted at Indigenous populations | Population of ~3500 people dispersed across 44 communities; 60% Aboriginal, with many of the small communities 100% Aboriginal. | Compared with the national average, the demographic profile of the Fitzroy Valley population is young, with high fertility, but exhibits a high mortality, especially among adults aged over 40 years due to the high prevalence of chronic diseases. | Primary health care-based health service partnership model targeted at Indigenous populations. Aimed at enabling two service providers to work together in a more coordinated and integrated way, building on each organisation's strengths and delineating clear roles and responsibilities in order to minimise service duplication and competition for scarce resources. |

| First author (citation) | Year of Publication | State, Country | Setting | Remoteness scale or info | Community Demographic | Model summary |
|---|---|---|---|---|---|---|
| Rimmer [21] | 2015 | QLD, Australia | Primary health care and hospital settings | The Central West Health and Hospital Service district covers an area of 385,000 sq. kilometres, approximately 22% of the state of Queensland. It serves a resident population of 12,405 people which can double in the winter tourism season. The population is thinly distributed across the district. Longreach (3,356) and Barcaldine (1,655) and Winton (954) are the largest towns and smaller communities are located in smaller towns and on isolated pastoral properties. | A resident population of 12,405 people which can double in the winter tourism season. The population is thinly distributed across the district. | The model entails the provision of medical workforce for both the public and private sectors by the public health service, using a single employer of all clinical staff and a shared medical workforce within the district to eliminate competition for clinical resources. |

# Appendix C. Interview protocol for individuals familiar with the Collaborative Care approach.

| Target | Strategy Name | Collaborative Care Background | Question |
|---|---|---|---|
| Context | Create groups | The Collaborative Care approach establishes working groups with governance of the project who identifies need and establishes priorities, with the top 1-3 proceeding to the identification of barriers and enablers before developing and trialling a model and may need to address disagreement to obtain consensus on even seemingly straightforward issues e.g., credibility of Australian Bureau of Statistics data. | 1) How did this site get chosen as a suitable site for the Collaborative Care approach? How would you recommend towns be chosen as suitable or unsuitable for this approach?<br>2) One of the first things we've heard about the Collaborative Care approach is that it establishes working groups, then that working group sets its top priorities. Is that what happened at [site]? [If not] how did it differ/ what did you do instead?<br>3) Who was in your working group? Why were they included? [draw and label each onscreen]<br>4) If the Collaborative Care approach were to be used in another place, how essential do you think working groups are to the approach? [If yes], why? [If not], what would you recommend instead? |
| | Change the environment | The Collaborative Care approach secured Commonwealth funding to seed site-specific collaborations and instigate in-kind support from stakeholder organisations. It might also invest resources strategically e.g., budget and run a recruitment campaign to obtain the workforce required to establish a model (attempted in Lachlan Valley). | 5) What kind of funding did you need to start and maintain the Collaborative Care program at your site? [label on map]<br>6) What resources did other people pitch in – how much, and why? [label on map]<br>7) If the Collaborative Care approach were to be used in another place, how much funding do you think would be needed, and where should it go?<br>8) How long did the Collaborative Care process take? How many iterations were needed? What did primary healthcare services look like while this planning/establishment took place? |
| | Change the composition | The Collaborative Care approach aims to establish a representative sample of individuals within local working groups e.g., include local council members | 9) How did you decide who would be in the working group?<br>10) Who wasn't in your working group, that looking back, you think now should have been? Why do you think so?<br>11) If the Collaborative Care approach was used in another place, who do you think would be essential to include and why? [drawn an ideal network onscreen] |
| Actors | Change actors' networking skills | Depending on specific local needs and abilities, the Collaborative Care approach seeks to obtain and bring in subject matter specialist skills to a community, some of which specifically focus on relationship, such as a local linkage community project | 12) What were the challenges that your community was facing, that needed support from/ the benefit of a Collaborative Care approach? [label onscreen e.g., lack of collaboration or disputes between two parties]<br>13) What had you tried to address these issues before the establishment of working groups to start the Collaborative Care approach? |

| | | | |
|---|---|---|---|
| | | officer (i.e., expert in relationships and local politics), conflict resolution, Aboriginal engagement expert | 14) What did the Collaborative Care approach contribute to the establishment of a model at your site? (e.g., trust/ partnership, expertise in health service development/ planning) [label onscreen] |
| | Change actor awareness and/or knowledge of the network* | The Collaborative Care approach brings together geographically close communities and stakeholder organisations or individuals. | 15) Let's check how this picture looks – is everyone who the Collaborative Care approach brought together included? Are there any other new relationships we haven't drawn?<br>16) Let's label - what skills/input did each person/organisation provide? |
| | Change actor prominence | Depending on specific local needs and abilities, the Collaborative Care approach seeks to obtain and bring in subject matter specialist skills to a community, some of which might be technical in nature e.g., Researcher, project management, a communications expert for health literacy campaign for patients who want a known model with GPs (4Ts) | 17) Who provided leadership and governance? How effective do you think this was? [highlight onscreen]<br>18) Who do you think was really key to the success of Collaborative Care at your site? Why? [highlight onscreen]<br>19) What role do you think NSW Health can play in supporting Collaborative Care approaches? [draw hypothetical network onscreen] |
| | Change actor motivations to connect | The Collaborative Care approach aims to establish a common goal to align stakeholders. | 20) How successful do you think the approach was in aligning everyone to develop, implement or sustain a primary care model at your site?<br>21) If the Collaborative Care approach were to be used other places, what advice would you give to align everyone to the goal of developing/implementing/sustaining the model? |
| Ties | Change specific ties | The Collaborative Care approach identifies relevant relational barriers to the establishment of a model e.g., Lack of trust between key partners (e.g., Parkes and Forbes in Lachlan Valley) | 22) If the Collaborative Care approach were to be used other places, what challenges do you think a community would face? How do you think they should be overcome? |

# Appendix D. Interview protocol for NSW health system stakeholders.

| Target | Question |
|---|---|
| **Innovation** | Overview to be provided to orient the interviewee to the program, using the overall and site-specific maps as a visual prompt. |
| **User organisation** | 1) From [interviewee's organisation]'s perspective, is there a perceived need or priority for Collaborative Care in NSW?<br>2) Within [interviewee's organisation] is there likely to be any opposition to a Collaborative Care approach? If so, who and at what level? What would need to be done to strengthen perceived need and/or reduce opposition? How can new champions be mobilised?<br>3) What role do you think [interviewee's organisation] could play in scaling up NSW? What resources or limitations would ACI have in supporting Collaborative Care? |
| **Environment** | 4) From [interviewee's organisation]'s perspective or experience, where do you think there is likely to be support for Collaborative Care? Where do you think there is likely to be opposition?<br>5) What could be done to strengthen supports for Collaborative Care? How could collaboration be established with supportive organisations?<br>6) What could be done to reduce opposition to Collaborative Care? |

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