Wentworth Healthcare

Response to the

Primary Health Reform Steering Group

Draft Recommendations on the

Australian Government's Primary Health Care 10 Year Plan

July 2021

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NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Contents

Introduction

Wentworth Healthcare, provider of the Nepean Blue Mountains Primary Health Network (NBMPHN), welcomes the opportunity to respond to the *Draft recommendations from the Primary Health Reform Steering Group* on the Government's *Primary Health Care 10 Year Plan,* which aims to maintain and strengthen Australia's health.

Background

Wentworth Healthcare is provider of the NBMPHN which is one of 31 Primary Health Networks (PHNs) established across Australia to improve the coordination of Healthcare and increase the efficiency and effectiveness of health services for patients and communities during disasters and emergencies.

Areas covered include the four local government areas (Blue Mountains, Hawkesbury, Lithgow and Penrith) and covers 10,000 square kilometres with a population of approximately 377,000 people. WHL supports 139 general practices consisting of 502 GPs who conduct 2.7 million GP consultations per year. The region has 80 community pharmacies and over 1,400 allied health professionals.

We submit the following feedback as a mechanism to effectively communicate the importance of Primary Healthcare and encourage an enabling, integrated environment to better support patient-centered care that is timely, appropriate, agile and effective.

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NBMPHN response to theme 1: Person-centred health and care journey, focusing on one integrated system

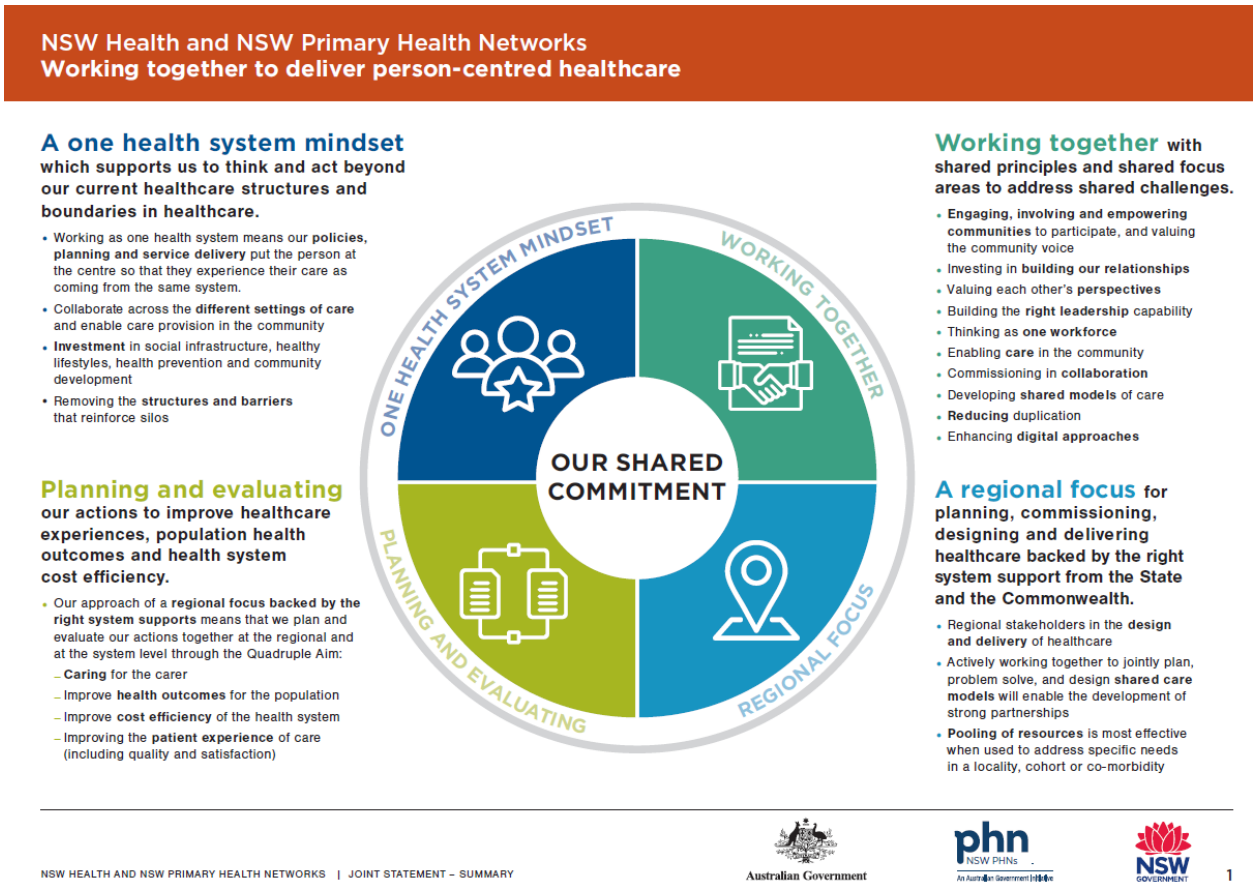
Recommendation 1 (One system focus)

Reshape Australia's health care system to enable one integrated system, including reorientation of secondary and tertiary systems to support primary health care to keep people well and out of hospital.

NBMPN strongly supports the concept of a one system focus. NSW PHNs and NSW Ministry of Health have developed a joint statement of commitment which guides our work together and reflects this concept through quadrant one: *A one health system mindset* (see figure 1 below). This joint statement has in principle support from the Commonwealth and is currently with the Secretary of the Department of Health for formal sign off.

The work already underway between States and Territories with the associated Primary Health Networks should be further encouraged, strengthened and formalised as a platform for work to support a one system focus at a jurisdictional and regional level. Governance including clear obligations of all parties, is essential to the success of this so that it is not reliant on good-will of some and to reduce variable or optional implementation of the one system focus mindset.

Figure 1: NSW Health and NSW Primary Health Networks joint statement of commitment



Whilst the draft recommendations from the Primary Health Reform Steering Group identifies leveraging the long term joint reform agenda that the Commonwealth and the States and Territories have agreed to through the National Health Reform Agreement (NHRA) Addendum 2020-2025, NBMPHN recommends that these bilateral agreements between Commonwealth and the States and Territories should be trilateral agreements with the inclusion of Primary Health Networks (PHNs).

The NHRA Addendum identifies PHNs and their role in the health system. it is clear that to achieve the reforms set out in the NHRA, PHNs are critical. However, there is little relationship between the priorities and funding provided to PHNs through the Commonwealth Department of Health and the priorities identified in the NHRA. This should be considered in advice to the Australian Government on the Primary Health Care 10 year plan.

It is imperative that disincentives for a one system focus are identified and addressed. This includes perverse incentives encouraging people to receive care in settings that may not be the most appropriate. There must be an investment of funding to truly support a one system focus as outlined in action 1.2 (page 9).

In addition, barriers to data and information sharing between a person's healthcare team that may fall across the commonwealth, private and state health systems needs to be addressed. This is critical to build connected, multidisciplinary primary health care teams delivering flexible, innovative care and meeting community needs.

Recommendation 2 (Single primary health care destination)

Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice

The concept of a single primary health care destination is supported. This provides enormous opportunity for the provision of pro-active health and wellbeing care and VPR provides a platform for such a reform, to further build high performing, multidisciplinary, consumer-centred and integrated primary health care. The concept appears to be well supported by consumers, many of whom already identify they have a single primary health care destination.

It will be essential that the lessons learnt from the health care homes trial are considered and that appropriate change management is in place to support such a reform. Based on our (NBMPHN) experience in supporting the implementation of the heath care homes trial, it will be critical that primary care is engaged in the design and that there is a whole of practice approach to support work flows and business models. Carving off small cohorts for application of such a model is not recommended and primary care should be able to apply this to their entire practice population if appropriate.

System navigation and social prescribing are crucial to the success of a holistic care model and need to be funded appropriately.

At a practical level, incentives are required and barriers need to be addressed to promote the actual integration of care teams across health care practices and organisations. Specifically, systems and processes to track, support and facilitate patient journeys across the health system, such as in-practice care navigators and care facilitators, need to be developed, promoted, implemented and utilised. In this way patients will receive optimal integrated care at the most appropriate location, and be assisted in navigating the complexities of the local health care network. LUMOS data strongly

supports better patient and system outcomes by ensuring the tighter integration of primary and hospital services for admitted patients. System changes and extensions to facilitate this are critical to the effective operation of the single primary health care destination.

Recommendation 3 (Funding reform)

Deliver funding reform to support integration and a one system focus

NBMPHN agrees with the recommendation to deliver funding reform. This is essential to better support a one system focus, support best practice models of primary care, sustainable business models and the unique needs of different regions.

Models must consider funding drivers across the whole health system and across sectors to address unintended consequences that further silo care provision or lead to duplication. The value of applying local approaches and local solutions to funding models must be considered.

Reform that supports accountability and drives patient outcomes is welcomed. Funding reform must support collection, analysis, reporting and sharing of data to support quality improvement which is imperative for high performing and accountable primary care. PHNs are well placed to further support primary care in their use of data for quality improvement.

Recommendation 4 (Aboriginal and Torres Strait Islander health)

Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islander peoples through structural reform of the primary health care systems

4.7. Data and acknowledgement of data sovereignty

NBMPN strongly supports and acknowledges Aboriginal and Torres Strait data sovereignty while ensuring the data is available to contribute to the wider story.

NBMPHN response to theme 2: Adding building blocks for future primary health care – better outcomes and care experience for all

Recommendation 6 (Empowering individuals, families, carers and communities)

Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them

NBMPHN agrees with the actions identified to support this recommendation. There is an immediate need to support general practices and patients in the use of safe and practical virtual health options that consider workflows and time. Incentives to adopt such technology is needed recognising the investment and significant change management required for private practitioners. PHNs are well placed to support uptake of digital technologies if backed by the right incentives for primary care.

Systems need to consider how to embed health literacy with implementation of appropriate mechanisms that support increased health literacy within a diverse and complex health and wellbeing environment. This includes increased support digital health literacy for consumers to participate in this environment as an equal partner. There is a need for a clear strategy and practical solutions including investing in health navigators, both physically and virtually, as outlined in previous recommendations.

Recommendation 7 (Comprehensive preventive care)

Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support

It is imperative that reform addresses the current barriers to provision of comprehensive preventative care through primary care. Actioning this recommendation is supported by VPR, which encourages a whole of patient population view with the ability to plan more proactive care. Supports need to be available to keep people well, not just once they have a disease. A whole of system focus is required and a shift in the care and funding models that currently disincentive preventative care. PHNs can support primary care at a practice level and at a regional level, both in terms of use of data and local supports.

Recommendation 8 (Improved access for people with poor access or at risk of poorer health outcomes)

Support people to access equitable, sustainable and coordinated care that meets their needs

NBMPHN welcomes the recommendation which recognises and seeks to address health disparities and the communities that are most affected. There is a need for increased support and resourcing for primary care services providing care to communities with a higher proportion of disadvantaged individuals, to build their capacity and capability to respond and address the complex needs and barriers to equitable health outcomes. NBMPHN supports actions that recognise the need to tailor approaches to better meet the needs of disadvantaged individuals and communities.

NBMPHN response to theme 3: Leadership and culture

Recommendation 9 (Leadership)

Foster cultural change by supporting ongoing leadership development in primary health care

NBMPHN believes in a strengthened primary care leadership, one that is able to articulate the needs of individual practitioners and extrapolate these at a broader regional, state and national level. This culture of leadership and the platforms that drive change can be effectively fostered by increased opportunities at a regional level to support growth and development. The acknowledgement that change takes time and requires resource investment is incredibly important for success with structures in place to support the adopted change process.

Primary care leadership needs to fostered and grown from among the ranks of practicing primary health care clinicians. PHNs are ideally placed to identify local leaders and implement leadership development programs which deliver strong and informed local leaders focused on relevant issues and practical solutions.

NBMPHN response to theme 4: Primary care workforce development and innovation

Recommendation 10 (Building workforce capability and sustainability)

Address Australia's population health needs with a well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce

NBMPHN supports this recommendation and acknowledges the importance of a skilled and supported workforce to address the population health needs. The linkage of strategies to address the needs of both our most vulnerable population groups and those of our general population are essential at a national level enabling the localisation of strategies to meet the workforce needs, ensuring adaptability in regional and remote locations. NBMPHN recognises the need to address primary care workforce shortages in GPs and the allied health workforce. It is important that the

workforce challenges of peri-urban and outer-metropolitan regions are not forgotten. These regions 'fall through the cracks' between rural areas, which have dedicated workforce incentives and supports, and urban areas which are seen as more desirable places to live and work.

Recommendation 11 (Allied health workforce)

Support and expand the role of the allied health workforce in a well integrated and coordinated primary health care system underpinned by continuity of care

NBMPHN supports improved digital infrastructure and integration of these structures for allied health with the rest of primary care. The current lack of digital connectivity amongst primary care services is a significant impediment to building a more coordinated and connected service for patients. Subsidisation and incentives for allied health practices to increase digital capability and capacity is well overdue and should be prioritised.

The financial sustainability of private allied health professions needs to be considered and we welcome consideration of funding and care models that support a more multidisciplinary approach.

Any recommendations relating to clinical governance need to consider the significant number of different accreditation schemes allied health need to comply with in order to provide services to particular client groups. This needs to be reviewed and consolidated as the workload and costs act as a disincentive for allied health to provide services, which limits access to some of the most vulnerable groups e.g. people with disabilities.

Recommendation 12 (Nursing and midwifery workforce)

Support the role of nursing and midwifery in an integrated Australian primary health care system

NBMPHN support this recommendation, specifically the need for funding reform to support and encourage high caliber workforce in primary care enabling nursing and midwifery to work at the full scope of their practice. Primary care nursing must be incentivised in order to achieve this. As outlined this would provide more opportunities for integration and collaboration improving the capacity of primary care providers.

Integration of funding reform to achieve the action outlined at 12.8 will be a significant undertaking and requires a strong authorising environment at a Federal and State or Territory level, however is vital for improved health outcomes at a community level.

Recommendation 14 (Medical primary care workforce)

Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce

NBMPHN support this recommendation, which recognises both enhancing the roles of General Practice to move beyond reactive care models to a more whole person, proactive, planning, care delivery and team leader function, and the need to focus resources and energies towards sustaining and supporting the whole medical primary care workforce.

By investing in GP and rural generalists as leaders of local primary care teams, and by recognising and adequately funding the structure and operation of a nationwide network of PHN auspiced and connected local health neighbourhood primary care practice hubs, effectively linked to and integrated with community GP, allied health and specialist practice locations, and with local hospital networks, issues such as career pathway, mentorship, training, peer review, population health management, teaching, resource and service planning, locum provision, specialist integration and support can all be addressed proactively. Consequently local medical primary care workforce planning, supply and operation will be actively supported and able to better merge both local needs and national priorities. Further best practice training, delivery, bench marking and quality improvements processes will be able to be actively delivered, promoted and incorporated into daily care delivery activities.

NBMPHN response to theme 5: Innovation and Technology

Recommendation 15 (Digital infrastructure)

Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care

NBMPHN supports a greatly strengthened interoperable system that enables acute, secondary and primary care greater, faster and more agile communication. There are currently many barriers to this from disparate governance systems to the availability of practical systems and tools, including those that support better integrated point of care. There are few communication enablers to foster the safe sharing of care and transition of care for a consumer across these sectors.

An agreed national infrastructure needs to be developed and a road map to achievement of this. Currently investment in bespoke solutions has its limitations.

Data ownership and overcoming barriers to information exchange needs to be considered. The potential for better health outcomes and reduced costs is significant.

NBMPHN response to theme 6: Research, data and continuous improvement of value to people, population, providers and the health system

Recommendation 17 (Data)

Support a culture of continuous quality improvement with primary health care data collection, use and linkage

PHNs are well placed to support this recommendation and have demonstrated leadership in supporting a culture of continuous quality improvement with primary care.

NBMPHN participates in the NSW PHN/NSW Health LUMOS project and richness of information that results from being able to see and understand what is occurring across the patient journey, allows practitioners to better tailor care for patients. There is also enormous potential for data to provide a better view of health at a national level and support initiatives to address population health needs.

However feedback from general practices continues to highlight the need for support at a practice level to ensure data is accurate and well curated. There is a significant commitment of time and therefore cost to a practice. Even GPs with a strong commitment to data quality improvement highlight the lack of resourcing and therefore reality of transferability across all practices nationally. At a State level, there are dedicated roles to support data collection and quality improvement. The need for resourcing also needs to be recognised in primary care and we implore the steering committee to consider appropriate incentives to support high quality data and utilisation of this.

Recommendation 18 (Research)

Empower and enable contextually relevant, translational and rapid research and evaluation in primary health care, addressing questions directly relevant to service delivery in localised context

Supported

NBMPHN response to theme 7: Emergency preparedness

Recommendation 19 (Primary health care in national and local emergency preparedness)

Deliver nationally coordinated emergency preparedness and response, defining Commonwealth, State and Territory roles and boosting capacity in the primary health care sector

NBMPHN strongly supports this recommendation. There is need for immediate action to create an enabling environment which will better prepare health services and associated stakeholders to prepare for, respond to and recovery from future disasters and emergencies.

Primary health care involvement in emergencies and disasters should not be reactive as is currently the norm. There needs to be investment to ensure primary care is prepared and ready to respond to disasters and emergencies. Much of this work needs to happen when there is not a disaster, at a time when it isn't 'sexy' to invest in this work. We must move away from purely reactive funding or calls for primary care support during a disaster and truly integrate primary care into disaster and emergency preparedness as well as response and recovery. Primary care play an important and unique role that needs to be defined and clearly articulated to all parts of the health system, as NBMPHN has done. They do not and should not be regarded as duplicating existing responses and be supported in their role. PHNs, if funded, are key to supporting and coordinating the many primary care providers within a region to prepare and respond to emergencies and disasters.

There is an opportunity to build on the work and experience of NBMPHN

Our experience:

The Nepean, Blue Mountains region consists of a mix of urban, rural, bushland, industrial and commercial lands, as well as the Hawkesbury/Nepean river system and National Parks. It experiences extreme heat in the Penrith and Hawkesbury areas, and cold and snow conditions in the upper Blue Mountains and Lithgow. These conditions leave the region vulnerable to natural disasters and adverse weather conditions such as bushfires, flooding, droughts and heatwaves which in turn adversely affect health service provision to local communities.

The region experienced major bushfires in October 2013, snowstorms that closed the main highway in 2014 followed by major flooding in 2016 and March of this year. The region was part of the 2019/2020 Black Summer bushfires while in January 2020 Penrith recorded a temperature of 48.9 degrees celsius making it the hottest place on earth. These disasters played out against the backdrop of droughts, economic hardship and the COVID-19 pandemic.

Experience gained from the 2013 bushfires saw NBMPHN tailor its response plans to the continuing disasters making it better prepared to respond to surge capacity situations. To date NBMPHN has played a leading role in its disaster preparedness and response processes while sharing and promoting knowledge with other Primary Health Networks (PHNs). See here for our emergency preparedness guide for Primary Health Networks and others supporting the local General

Practitioner response during emergencies: https://nbmphn.com.au/NBMPHN-Library/Disaster-Planning

We also highlight the White Paper developed by the PHN National Network on the role of primary health Networks in disasters and emergencies which we recommend the steering committee consider when developing actions against this recommendation 19. The paper can be found here: https://nbmphn.com.au/Resources/About/The-Role-of-Primary-Health-Networks-in-Natural-Dis

The following feedback is submitted as a mechanism to effectively communicate the importance of Primary Healthcare and suggested capability requirements for PHNs to prepare for, respond to and recover from future natural disasters and emergencies.

19.1. Commonwealth/State responsibilities

NBMPHN acknowledges the responsibility of jurisdictions to deal with disasters and emergencies within their existing arrangements. It advocates for a greater voice to inform decision makers regarding key opportunities to build a collaborative, coordinated and capable Primary Healthcare disaster response system.

In many instances, Primary Healthcare delivers ahead of others in ensuring continuous community health during disasters.

These acknowledgements are aligned with the findings of the Royal Commission into National Natural Disaster Arrangements Report released on 28 October 2020 which states:

> "Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including representation on relevant disaster committees and plans and providing training, education and other supports," (Recommendation 15.2: Inclusion of primary care in disaster management).
>
> Royal Commission into National Natural Disaster Arrangements 2020

It is therefore essential that the role of PHNs be formalised and embedded into future disaster preparedness, response and recovery processes.

In addition, NBMPHN recognises the importance of engagement and collaboration between Aboriginal Community Controlled Health Organisations (ACCHOs) in the disaster management process. From this, NBMPHN is implementing tangible local actions which will continue to support the safety and well-being of Aboriginal people during emergency events. By applying an integrated approach, NBMPHN will seek to identify interest on the part of Aboriginal health organisations and practices to work collaboratively towards more formalised, localised and better resourced strategies in disaster management planning for Aboriginal communities.

19.2. Commitment to Closing the Gap

NBMPHN acknowledges the priorities for improved community health, disease prevention and reduced hospital presentations of vulnerable communities by ensuring access to high quality primary healthcare service to Aboriginal and Torres Strait Islander peoples.

This includes working alongside internal and external Aboriginal and Torres Strait Islander Health Workers, Practitioners and government stakeholders to develop a shared agenda that is focused on preventive health management and wellness to improve health outcomes. NBMPHN also recognises that identifying areas of disaster risk and managing the solutions to health outcomes for Aboriginal and Torres Strait Islander health will be achieved through:

- Forming formal partnerships and shared decision making with Aboriginal and Torres Strait Islander health services and affiliated organisations to prepare for and respond to health risks during disasters.
- Building and strengthening current collaborative structures to empower Aboriginal and Torres Strait Islander peoples to share decision-making with PHNs when planning for disasters.
- Ensuring that vulnerable and disadvantaged groups have a voice and that there is a focus on supporting communities most in need.
- Enabling shared access to location specific data and information to support Aboriginal and Torres Strait Islander communities and organisations better prepare for, respond to and recovery from disasters.
- Identifying and supporting opportunities for access to health education and training opportunities for the Aboriginal and Torres Strait Islander workforce.

NBMPHN acknowledges that action is required to influence the provision of primary care to include recognition of the impact of disasters on Aboriginal and Torres Strait Islander health. As PHNs provide a unique link between communities and health services during disasters, it is essential that they be recognised across government and the healthcare workforce if equality of health outcomes for Aboriginal and Torres Strait Islander peoples are to be achieved.

19.3. Frameworks for local integrated solutions

Primary care providers are progressively being integrated within disaster management systems at the local level, primarily through stronger linkages between PHNs and Local Health Districts (LHDs).

However, PHNs are not funded by the Australian Government to undertake an emergency management role, although they have the flexibility, local knowledge and partnerships to perform these functions during disasters.

NBMPHN has developed a Disaster Management Framework which acknowledges the responsibility of all jurisdictions to deal with disasters and emergencies within existing arrangements. The focus of the Framework is to ensure NBMPHN has the capabilities required to manage disasters and promote collaboration with relevant stakeholders to fill existing gaps in health service delivery.

In addition, NBMPHN works towards a coordinated response system through multi-agency partnerships across the prevention, preparedness, response and recovery spectrum. To achieve this, NBMPHN works closely with local disaster management groups, Government authorities and primary health providers such as GPs, nursing, allied health, mental health, first responders and pharmacies to actively support their disaster management responsibilities.

NBMPHN submits that primary healthcare has a pivotal role in shaping future planning and management of pandemics and disasters through its integrated primary care initiatives and local partnerships and networks.

NBMPHN has the capabilities and capacity to play a formal and supported coordinating role in the disaster management context. This is on the basis that PHNs are ideally positioned to support primary care providers and ensure uniformity of health service provision during disasters.

19.5. Allied health roles in emergency response

During an emergency or disaster, NBMPHN adopts a multidisciplinary approach by communicating regularly with Allied Health Professionals (AHPs) to determine the most effective and appropriate response.

For example, during the March 2021 floods, NBMPHN worked with the Allied Health sector to ensure continuity of health care during the incident by collaborating with pharmacies, psychologists, counsellors and social workers and a range of health service providers. Community pharmacists played a vital role in flood affected areas by continuing access to medications and providing appropriate health advice and information.

The collaborating involved assisting AHPs to address the health needs of vulnerable community members and ensure continuity of care during the disaster. It is essential there is an overarching body and voice for the many different primary care providers, to coordinate the primary care response across the region and provide the link to the overall emergency response chain of command and structures

Allied Health Clinical Council (AHCC):
NBMPHN's Allied Health Clinical Council advises its Board on recommended strategies to address region-wide issues facing AHPs while also considering the unique needs and concerns of each local community. The AHCC represents AHPs within each LGA, ensuring all AHPs have an opportunity to share their concerns and ideas, regardless of their location in urban, rural or remote communities.

In addition, NBMPHN continues to work closely with AHPs to embed new and improved ways of developing capacity and delivering health care particularly in relation to vulnerable individuals and communities during disasters.

Such PHN initiatives have the possibility of being adapted and expanded to better mobile and support the allied health workforce around disaster management, if PHNs are appropriately resourced.

19.6. Primary health care during emergency response

There is an appetite for PHNs and primary care providers to become integrated within current disaster management systems at the local level, however an authorising environment is required at the State and Federal level to support such approaches to ensure consistency and to reduce the reliance on 'good will'.

NBMPHN's partnership with the LHD is an example of what can be achieved at the local level, ensuring both organisations work productively together across the entire district. Agreed shared priorities include aged care, mental health and improving access to after-hours general practice care, child and family health initiatives, population health, eHealth, and improving the information flow between the organisations to facilitate improved services to the local population.

For example, in response to the challenges experienced in the 2019-2020 bushfires and recent floods, NBMPHN and Nepean Blue Mountains Local Health District (LHD) are currently updating their emergency response plans to map and integrate the functions of each agency for future disasters. It is anticipated this will reduce the likelihood of resource wastage, double ups and confusion in relation to the associated roles and responsibilities of each agency.

Maintaining access to primary health care services, especially general practice and community pharmacy, during an emergency situation can present inappropriate or avoidable hospitalisations. NBMPHN has demonstrated that GPs have a role to play in providing medical assistance at emergency evacuation centres and/or from their practice if supported. This includes remaining open, extending practice hours and seeing patients from other practice. To do this, there needs to be an information link between the broader disaster response and practice with local intel and communication both ways.

NBMPHN example as a coordinator during the 2019/2020 Black Summer Bushfires:

GPs on the NBMPHN emergency volunteer register were communicated with regularly and were on alert in case they were needed at an evacuation centre. 'Evacuation centre kits' were ready to deploy to GPs if they were required to attend an evacuation centre. The kits contain resources and tools GPs would need in addition to their own doctor's bag. For example additional medical equipment and first aid supplies, identifying vest (fluoro/ reflective tabard with DOCTOR emblazon) so they could be easily identified, blank script pads and blank note pad, triplicate pad of patient summary forms, list of relevant contact numbers, local pharmacy etc.

Regular communication was distributed to all general practices in the region to keep them up to date with the situation, alert them to relevant resources and communicating what they could do to assist from their practice (i.e. stay open longer hours if required in some regions, willingness to take new patients etc.).

When we were informed by the LHD of the location of potential evacuation centres, staff could target surrounding general practices and collate information about opening, capacity etc so this could be provided to people attending the emergency centres if they opened. A list was provided to LHD of these practices, opening hours and also of local pharmacies.

PHN practice liaison officers undertook regular check ins and were able to monitor practice closures, opening times, and could quickly respond to any issues experienced by practices. We knew what general practice coverage was available in the region and could identify any gaps.

Throughout the bushfire crisis, we maintained ongoing communication with LHD. Our PHN participated in the health Emergency Operations Centre meetings (sometimes up to three times a day), sharing information to assist in a more coordinated response. For example, we could share information on Practice openings and where people could attend if they were evacuated. As an example, one weekend there was an evacuation centre set up in Lithgow. The Local Health District requested a GP to go to the centre as they were concerned people would not have access to a GP for scripts and minor issues. They wanted to prevent avoidable presentations to Lithgow Hospital Emergency Department, which was already understaffed and reporting capacity issues with smoke inhalation from fire services personnel and others. The entire region was cut off due to the fires blocking major roads and it would not have been possible to get a GP from the volunteer register into the city centre. The PHN was able to identify, liaise with, and share information about, a General Practice in the town centre close to the evacuation centre that was open over the weekend on Saturday and Sunday extended hours and were willing to see new patients / patients from other GPs. Staff in the evacuation centre were able to refer evacuees to this practice rather than ED

There should be national consideration of item numbers for primary healthcare providers that can be utilised during a natural disaster response to ensure primary care services can be provided in alternative locations if required.

Other suggested approaches include:

- Promotion of the benefit of the My Health Record with providers during disasters
- Emergency provider numbers for GPs
- Continue telehealth item numbers for rural and urban areas
- Widely available e-prescriptions
- A well-coordinated medical surge workforce
- Easing of access criteria for mental health support e.g. removing the need for a diagnosis or a Mental Health Treatment Plan in order to access Better Access to Psychological Services

19.6.1. Primary health care in disaster management

Committees:
NBMPHN participates in regional and local disaster management committees and planning processes to provide input and seek direction and advice for strategic and operational health emergency management processes. This includes the LHDs Emergency Management Executive Committee. This increases the profile or and awareness of the role of primary care in an Emergency and ensures there is a seat at the table for the primary care voice. We have identified GP leaders and those with a special interest in emergency response, who have work with the PHN to develop a regional approach to supporting the primary care disaster response and role. NBMPHN represents PHNs at the RACGP's NSW/ACT GP Disaster Management Committee. There is potential for primary care to be involved across all regions of Australia if there is a supportive and authorising environment created which requires involvement of the Federal and State governments.

Training/education:
NBMPHN recognises the importance of primary healthcare providers being specifically trained in emergency management structures and systems and agrees with this action. NBMPHN provides

dedicated training and capacity building, education activities and arrangements to support primary healthcare providers and GPs who volunteer during disasters. This can be replicated across other regions.

NBMPHN builds the capacity of local Healthcare service providers through:

- Major Incident Medical Management Support (MIMMS) training, an internationally recognised qualification, offered to GPs in the Nepean Blue Mountains region (mandatory for GPs on the emergency volunteer list).
- Educational courses for volunteer GPs/pharmacies on creating Business Continuity Plans (BCPs) and becoming 'disaster ready.'
- Training for general practice managers and staff in preparing for and responding to disasters.
- The Emerging Minds Community Trauma Toolkit provides information, education and mental health resources to assist GPs when having conversations with patients about the impacts of disasters.
- NBMPHN coordinates the provision of relevant information and feedback mechanisms following disasters to inform future training.
- Provide presentations to health members across NBMPHN including guest speakers, local community members and first responders such as SES/NSWRFS and LHD personnel.

A formal acknowledgement of the role of PHC in disaster management would facilitate NBMPHN's ability to engage with relevant stakeholders more broadly across the PHNs program to discuss issues related to the design and/or building of collaborative disaster management initiatives.

19.6.2. Response networks

Implement and expand rural emergency response networks (RERN), building on RERNs currently in Australia and lessons learned from international experience.
NBMPHN supports this action.

19.7. Mature PHNs and partnerships

The increasing frequency of disasters suggest a more cohesive approach between health service providers and stakeholders is required as disasters and emergency events have substantial potential health effects on communities.

Primary Health Networks play a significant role throughout the continuum of disaster management. Because of their flexible scope of practice, PHNs are well placed to be involved during disasters, from planning to direct response when a disaster occurs and in leading the way to recovery. As disasters increase, it is essential that disaster management is integrated and coordinated between all key stakeholders and the role of primary care and PHNs is recognised and supported by all levels of government.

PHNs are skilled at coordinating primary healthcare with other levels of the health system and can bring their infrastructure and capacity if their role is recognised and embedded in formal operational

relationships. If approaches build on the capabilities of PHNs, primary healthcare providers can be fully integrated and add value to the disaster response process.

As primary health care organisations, PHNs are well-placed in times of crisis, to be at the forefront of responding to these impacts. By leveraging the interdisciplinary skills of its primary health workforce, PHNs are well positioned to coordinate a strong primary health care response in disaster situations.

In addition, PHNs aim to promote people's health and wellbeing by increasing the efficiency of the healthcare system and reducing hospital use. Therefore, it is essential to ensure that funding, policy and process levers enable all professions and sectors of the primary health workforce to contribute to addressing health care demands during disaster and emergency incidents.

19.8. Mental health services during disaster recovery

Many PHNs have developed and facilitated strong connections within and between mental health service providers following the plethora of disasters that have occurred over the past few years. It is important that the sustainability and ongoing support is considered in communities as there has been much criticism from both community and primary care providers about the 'fly in and fly out' nature of support. Whilst this needed during and immediately following a disaster, there must be consideration of supporting local primary care providers who will provide the ongoing care and support for a community. General practices for example, need to offer their patients support when the initial horror of a disaster has been forgotten by other parts of the country. In addition, supports must be considered for primary care providers themselves who are part of the community and also impacted by disasters and the associated recovery.

19.8.1. Local planning and delivery

Refine arrangements to support localised planning and delivery of appropriate mental health services during the recovery phase of a disaster. It has been demonstrated that in order for post-disaster recovery to succeed, it needs to be community-led. Mental health providers working on the ground, as well as other non-government organisations know their communities and populations and are well-placed to identify the services, interventions and initiatives that have a chance of success.

It is imperative that there is coordination of services to ensure there is not duplication in some areas and gaps in others.

19.9. Data

Enhance health and mental health datasets to measure and share health impacts related to disasters, including mental health impacts both immediately and through the recovery phase.
NBMPHN supports this recommended action. The effects of the 2019-20 Black Summer Bushfires are still being realised in the region. It is important to have health and mental health data sets to show the impacts of disasters.

Conclusion – recommendation 19

Disasters and emergencies are increasing in prevalence and impact with Australia experiencing high levels of exposure to extreme weather events in recent years. Bushfires, droughts and floods and the ongoing COVID-19 pandemic has shown how quickly systems can shift and how integrated, value-based care is vital to a resilient and agile health system.

As emergency management arrangements require varying health agencies to 'surge' during disasters it is now more important than ever for the health sector to prepare for the impact of disasters on primary care practices and service provision.

Currently, PHNs are not formally included in health emergency response and disaster management planning. The extent of their participation is ad-hoc and varies between local areas and jurisdictions. This results in roles and responsibilities of primary healthcare providers and PHNs not being clearly defined which can impede the delivery of health services during and after disasters.

However, while the importance of primary healthcare is recognised, it is not supported by current funding models. In addition, the use of PHNs in current management processes is limited with no single solution to integrating and expanding primary care into disaster management systems.

Theme 7/Recommendation 19 highlights the need to include PHNs in disaster management arrangement at local, regional and state levels.

As PHNs have the experience and capabilities to coordinate the PHC response before, during and after disasters, the mobilisation of financial support along with integration and expansion within the wider health response at regional and state level is essential for these recommendations to be successful.

NBMPHN response to theme 8: Implementation is integral to effective reform that delivers on the Quadruple Aim

Recommendation 20 (Implementation)

Ensure there is an Implementation Action Plan developed over the short, medium and long-term horizons.
Ensure consumers, communities, service providers and peak organisations are engaged throughout implementation, evaluation and refinement of primary health care reform.

NBMPHN agrees that an implementation action plan is essential to move the recommendations from concepts to reality. This needs the input of key primary care stakeholders, consumers and community, all of whom are integral in driving reforms and accountability for reforms. There is a

significant amount of work to achieve the ambitious reforms over the next 10 years, many of which require bold systemic changes.

NBMPHN implores the steering committee to recognise and formally involve PHNs in implementation plans as they will be integral in operalisation and supporting change management in primary care, particularly general practice. PHNs have a regional footprint and work closely with general practices. They have a track record of supporting change and uptake of new initiatives. Most PHNs had over 50% of practices reporting data to the PHN and participating in data quality improvement initiatives prior to the QIPIP. This demonstrates the good will and relationships PHNs have with general practice even without financial incentives to do so. The rate of general practices reporting data to their PHN has increased further (80% or more) since the introduction of the QIPIP incentive.

NBMPHN is informed by primary care clinicians through various mechanisms including but not limited to formal and active clinical councils (general practice clinical council, allied health clinical council, and the multidisciplinary integrating care clinical council); a consumer advisory committee; a mental health consumers and carers committee; employed GP and Allied health clinical advisors (on staff); healthpathways clinical editors; clinician, consumers and carers on specific steering and program advisory committees including our aboriginal mental health and AOD steering committee; primary care clinicians as Directors on our Board; key primary health care peak bodies as members of the Company; and our day to day interaction with general practice and other primary care providers on the ground. NBMPHN has strong relationships with Residential Aged Care Facilities, the aged care sector, our LHD and many other key stakeholders that are integral to successful implementation of the draft recommendations from the Primary Health Reform Steering Group. Whilst the mechanisms for engagement with consumers and key stakeholders in the healthcare system may be slightly different for each PHN due to different regional needs and structures, all PHNs have strong relationships with their communities, primary care and the broader health care sector. Whilst PHNs are relatively new in the healthcare landscape, they have a wealth of knowledge about their region and communities and are able to localise implementation to meet these unique needs. PHNs must be engaged in the next steps of this change agenda.

NBMPHN particularly welcomes the introduction of formalised regional planning and governance between PHNs and LHNs. At a regional level, NBMPHN and NBMLHD have strong relationships and established governance mechanisms, including an integrating care joint board subcommittee which provides formal oversite to our joint activities, and a patient centred co-commissioning committee. However a stronger authorising environment is needed at a State and Commonwealth level with obligations and accountability to deliver on the quadruple aim This will support the sustainability of work happening at a regional level and enhance more innovative opportunities such as funds pooling and greater sharing of resources.

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