



An Australian Government Initiative

Submission to Unleashing the Potential of our Health Workforce (Scope of Practice Review)

Contact

[Redacted contact information]

[Redacted contact information]

Primary Health Network (PHN) Cooperative

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Executive Summary

This submission provides a coordinated response from PHNs across Australia to the broad questions raised in the first phase of consultation of the Scope of Practice Review. It highlights the potential contribution PHNs can make to supporting professionals and teams to work to full scope of practice, drawing on PHN experience, identifies important local and national context for the Review, and the opportunities presented by recent Federal Budget measures in which PHNs play a role. Potential criteria for assessing options to reform scope of practice are also proposed.

The key functions of PHNs are to **coordinate** and integrate local health services in collaboration with Local Hospital Networks (LHNs), to **commission** primary care and mental health services to address population health needs and gaps, and to **capacity-build** and provide practice support to primary health care providers. Through these functions PHNs play a key role in the collaborative planning, co-design and targeted commissioning which is needed to build capacity and capability of the local workforce, including potential for professionals to work to full scope of practice.

PHNs consider that to appropriately support the primary care workforce to work to full scope of practice there is a need for coordinated local action supported at a national level by resourcing, clear messaging and authority through governments and peak bodies. Local action, led by PHNs in collaboration with LHNs and other stakeholders, will help to ensure that place-based approaches are planned, co-designed and implemented for supporting multidisciplinary teams to utilise the full scope of practice of all team members to address the specific needs of communities. This local action can be informed by local and national workforce data and analytics initiatives in which PHNs have a role, such as the Workforce Planning and Prioritisation Program.

Significant opportunities for developing strategies for enabling professionals to work to full scope of practice are available through utilising the role of PHNs within recently announced Federal Budget Strengthening Medicare measures. This includes leveraging funding for encouraging multidisciplinary team-based care, trials of marketing-strengthening approaches for care in thin markets, support for nurse practitioners and the MyMedicare initiatives in an integrated way at a local level.

Implementation of these measures will need to consider the complexities and problems which are contributing to thin and failing markets and the pressures currently on the primary care workforce, and the broader incentives and programs available to the workforce to address these pressures.

The submission considers the system, service and provider level barriers and enablers associated with achieving full scope of practice. It notes potential benefits for all consumers in terms of improved patient experience and better outcomes if more optimal use of workforce skills can be utilised to target community need. Particular benefits for groups with access to a limited range of professionals can be achieved if place-based approaches are planned which support all members of multidisciplinary teams to work to scope to meet consumer needs, including non-clinical members such as clinical assistants, assistant allied health workers and mental health peer workers.

Potential risks of encouraging professionals to work to full scope of practice need to be identified within the local context and carefully mitigated including through clear clinical governance, skill building, and timely access to digital and virtual support and supervision. In addition, working to scope must be communicated and planned in a way which enables providers to utilise their skills to meet patient needs, not in a way which could imply or cause additional workforce pressures.

The submission **recommends** that:

1. The role of PHNs in local collaborative planning, capacity building and commissioning should be recognised and harnessed in strategies to support the primary care workforce to work optimally to their full scope of practice;

2. At a national level a clear authorising environment is provided by government but also peak bodies to address ambiguity in roles and enable PHNs and local services to confidently plan for and communicate the potential and value of working to full scope of practice;
3. Implementation of the Strengthening Medicare Budget measures which formed part of the 2023 Federal Budget should support and explore the role of PHNs in facilitating opportunity for professionals within multidisciplinary teams to work to full scope of practice, in the context of broader workforce pressures and existing workforce incentives and programs;
4. The experience of PHNs in co-designing place-based workforce solutions with stakeholders which optimise scope of practice to address unmet need particularly in thin or failing markets should be considered by the review, as outlined in Appendices to this submission;
5. The enablers at a system, service and provider level which supported the agile response to COVID-19, including workforce responses coordinated through PHNs, are worth further analysis as part of the review. This should include the authority and commitment to collaboration which provided a foundation for working to full scope of practice for a range of professions to meet community need.

1. Introduction and Context

About this submission

This submission has been prepared by the PHN Cooperative to provide initial, coordinated input from Primary Health Networks (PHNs) across Australia on the opportunities and challenges raised in the Department of Health and Aged Care Scope of Practice Review. The PHN Cooperative was formed in 2017 by the CEOs of the 31 PHNs. It is a joint initiative of the PHNs and a commitment to collaboration and delivering on the national agenda in primary health priority areas.

The submission comprises three separate sections:

- An introduction to the unique role and experience of PHNs in locally planning and commissioning primary care services in partnership with the primary health workforce and other key stakeholders, and the current policy and program context;
- A PHN perspective on the key focus areas of the review, including a vision for unleashing the potential of the workforce through supporting professionals to work to full scope of practice;
- Responses to the specific survey questions asked by the Review, supported by case studies from PHNs.

The focus throughout this submission is on the governance, culture, planning, coordination and commissioning issues which are within the realm of PHN responsibilities.

PHNs and their role in Primary Care Workforce Solutions

In 2015, the Australian Government's PHN Program established 31 PHNs nationally to strengthen primary care, improve patient-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians; particularly those at risk of poor health outcomes. The key functions and activities of PHNs are to:

1. **Coordinate** and integrate local health care services in collaboration with Local Hospital Networks (LHN) to improve quality of care, people's experience and efficient use of workforce and other resources;
2. **Commission** primary care and mental health services to address population health needs and gaps in service delivery and to improve access and equity;
3. **Capacity-build** and provide practice support to primary care and mental health providers to support quality care delivery.

PHNs support their local primary health care workforce through planning, co-design, and targeted commissioning to build capacity and capability and are also positioned to support coordinated primary health care responses to address the needs of underserved groups, and to respond to emergency and natural disasters. PHNs are intermediaries and coordinators of the primary health care system, with unique local knowledge, understanding for the national context, and the ability to generate insights and interpret local data.

Related Measures and Context - Promoting Multi-Disciplinary Team Care

Consideration of ways to unleash potential for full scope of practice within the primary care workforce must be contextualised in the broader pressures and limitations of that workforce and

existing measures in place to address these pressures. The overall short supply and/or maldistribution of many providers, particular pressures faced by primary care workers in some locations or for some service types, such as mental health presentations, and broader capacity and professional support issues, will all impact upon scope of practice issues. Practical issues like access to housing for primary care workers in remote locations, particularly for professions like Aboriginal Health Workers also need to be considered in integrated primary care workforce strategies.

The Scope of Practice review has close links to a number of parallel inquiries, and recent reports and Budget initiatives which promote best practice multi-disciplinary primary care and in which PHNs have an important role and/or interest.

- The **Australian Government's Primary Health Care 10 Year Plan 2022-2032** included a strong focus on 'Stream 3 – Integrated care, locally delivered'. Through this the importance of joint planning and collaborative commissioning to drive local solutions was emphasised. The Plan also acknowledged that state and territory governments and the Commonwealth should provide an authorising environment for joint planning and commissioning.¹
- The **Strengthening Medicare Taskforce** recommended supporting "local health system integration and person-centred care through Primary Health Networks (PHNs) working with Local Hospital Networks, local practices, ACCHOs, pharmacies and other partners to facilitate integration of specialist and hospital services with primary care, and integrate primary care with mental health, aged care, community and disability services". It also recommended increased commissioning by PHNs of allied health and nursing services to supplement general practice in underserved and financially disadvantaged communities.
- The 2023-24 Federal Budget 'Strengthening Medicare' package provided funding to **encourage multidisciplinary team-based care**. This included \$79.4 million over 4 years for PHN commissioning of multidisciplinary teams through funding for allied health and nurses in smaller and solo practices. It also provided support for nurse practitioners working in a team environment through an MBS rebate increase and PBS prescribing arrangements.
- Through Budget funding for Increasing Access to Primary Care, trials of market-strengthening approaches for **Supporting health, care and support services in thin markets** are also to be undertaken to support intervention where primary care fails or is unsustainable. PHNs are to have a significant role in these trials and have opportunity to consider ways of working to full scope to help address thin market issues.
- Other highly relevant MyMedicare Budget measures include the **General Practice in Aged Care Incentive**, through which PHNs are anticipated to play a role in supporting MyMedicare registered residents of aged care facilities to be matched to GPs, and also the **Wraparound primary care for frequent hospital users** initiative providing tailored care for patients with complex chronic conditions.
- The **Ngayubah-Gadan Consensus Statement on Rural and Remote Multidisciplinary Health Teams** has provided a valuable resource which examines determinants of team effectiveness in rural and remote settings, including organisational culture and role clarity issues which are required.² Many PHNs have a strong interest in and commitment to helping to implement this statement.

¹ Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032, Commonwealth of Australia (Department of Health) 2022

² <https://www.health.gov.au/resources/publications/the-ngayubah-gadan-consensus-statement-rural-and-remote-multidisciplinary-health-teams?language=en>

- The **Independent Review of Health Practitioner Regulatory Settings** (Kruk Review)³ is also relevant and has reviewed regulatory settings for overseas trained health professionals, who are often placed in areas which have thin or failing workforce markets.
- The **National Health Reform Agreement** included as a core element a commitment to 'Joint Planning and Funding at a Local Level'. From a PHN perspective comprises a vital building block for workforce planning, governance and commissioning to enable the primary care workforce to work to full scope of practice.
- **The National Medical Workforce Strategy** – promoting a well distributed workforce aligned with community need.

In general, PHNs have a role to play in ensuring that parallel recommendations, and parallel funding streams have opportunity for integrated implementation at a national level. They also have a role in working with GPs to support implementation of measures which offer incentives for increasing access to care and expanding scope of practice. Design of implementation of new Federal Budget measures should ensure shared objectives, including promotion of working to full scope of practice, and for flexibility for locally coordinated implementation to optimally utilise funding opportunities to address community need.

Definitions used in this submission

The full scope of practice of a profession includes the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. The full scope of a profession is set by professional standards and in some cases legislation.

Working to full scope means working to the full extent of the profession's recognised skill base and/or regulatory guidelines, acknowledging that some functions may be shared with other professions, individuals or groups.⁴

³ <https://www.health.gov.au/our-work/independent-review-of-health-practitioner-regulatory-settings>

⁴ Queensland Government (2017), [Full scope of practice](#)

2. A PHN Perspective on the Review

Defining the Challenge

From PHN experience, the following challenges to optimising full scope of practice by primary care professionals should be considered. PHNs note that none of these challenges are insurmountable.

In many regions, **system issues** including inadequate local service planning and governance, rigidity or ambiguity of workforce roles, inflexibility and lack of integration between Commonwealth and State funded programs may inhibit the ability of primary care professionals to work to full scope of practice to deliver services. For example, lack of rapid and easy access to diagnostic results, treatment summaries and urgent care from the acute sector may impede ability of primary care to work to full scope. A key challenge is to address these system barriers to optimising workforce potential, to ensure that people across Australia can access timely diagnostic, treatment and referral services.

There is not always **clear authority** for PHNs to take the lead in working with LHNs, local private primary care services, workforce and other stakeholders to collaboratively plan, commission and connect workforce solutions to support professionals to work to full scope of practice. The challenge is for Commonwealth and State governments to ensure this authority for joint planning and commissioning is unambiguous.

Whilst all consumers are impacted by the issue to some extent, areas of **thin or failing markets, including many rural and remote areas**, are particularly exposed to risks of poor patient outcomes if barriers to utilising the full scope of practice of available health professionals are not removed. Some providers in these areas simply have no choice but to work to the top of their scope of practice. The challenge is to give priority to supporting primary care professionals who deliver services in these areas to build and optimally use their skills to meet community need, whilst more broadly promoting opportunity for all primary care professionals to work to full scope of practice.

There is a need for a focus on **place based approaches** which make optimal use of workforce resources and enabling professionals to work to full scope of practice, matching the workforce to local community needs, training, and the service landscape.

There is **limited job availability** offering clear opportunity to work to full scope for individuals, particularly for professions such as nurse practitioners. We need to create positions that offer well defined opportunity to work to full scope of practice.

Successful innovation is not routinely adopted. Models of care or pilot initiatives which have been shown to promote working to top or expanded scope, have not been standardised or scaled.

Local workforce are not routinely consulted and engaged in efforts to utilise the skills and capabilities of the primary care workforce and may lack ownership or not understand new models of care which promote working to full scope of practice.

On-line or digital decision support tools, training, supervision, feedback or other forms of workforce support are not being fully utilised to support professionals in rural or remote areas to work to full scope of practice.

Criteria for assessing options for reform to scope of practice

PHNs consider that clear and consistent criteria should be used to measure solutions to workforce challenges, including reforms to promote working to optimal scope. These criteria assume and build on a focus on the quintuple aims of health care which are respected internationally.

Focus on patient needs: The primary focus of reform must be on addressing identified patient needs, and accommodating variation in these needs

Improved patient safety and quality of care: Any reform to promote scope of practice should prioritise patient safety and the quality of care provided.

Enhanced flexibility and adaptability: Whilst standardised consistent approaches are needed, reforms should not only allow agility to adapt to local needs, but also to evolving demands such as emerging diseases, and opportunities such as technological advances.

Education and Training: Any workforce reform must be supported by having adequate training programs in place.

Workforce retention, recruitment and wellbeing: Any reform must demonstrate that it will maintain or improve clinician wellbeing and support the retention of skilled staff and attract new talent to the primary care workforce.

Practicality of implementation: Proposed reform must be subject to a reality check to ensure there are the resources, funding sources, and authority to support implementation. This includes alignment of reform with available technology, and resourcing to support all elements of implementation, including change management and coordination.

Financial sustainability and efficiency: Any proposed workforce reforms must be financially sustainable and help to improve the efficiency of the primary healthcare sector.

Equity and Access: Any such reforms promote equitable access to healthcare services for all segments of the population and avoid unintentionally exacerbating disparities in care such as in rural areas or on low socio economic groups.

A Vision for Supporting Primary Care Professionals to Work to Full Scope of Practice

Overall, PHNs have a vision for a primary healthcare workforce which is supported by shared planning, co-commissioning, pooled funding and a connected workforce at a regional, place-based level. This will reduce duplication of services and support multidisciplinary teams to deliver a range of integrated services based on community need, utilising their full range of skills and expertise.

This vision involves shifting from the current local service landscape to the above vision as follows:

Figure 1 – Shifting to a system that supports professionals to work to full scope

From	To
Focus on staying safely within the remit of professional roles with communities being delivered a scope that is profession centric	Focus on meeting consumer needs through provision of timely, quality services by professionals supported and encouraged to work to full scope of practice and utilise their skills and expertise
Siloed approaches to planning and commissioning at a local level, lacking clear national or state authority or mandate for collaborative, joined up action.	Joint local workforce and service planning by PHNs and LHNs working with other stakeholders including ACCOs, authorised and supported by Commonwealth and State Governments, to develop models of care and collaborative commissioning which support working to full scope of practice.
Ambiguity and poor understanding of scope of	Peak bodies act as thought leaders in promoting key messages/protocols about scope of practice. Co-design of

practice of different professions. Limited availability of roles that offer full scope of practice.	new models of multidisciplinary care and services will enable shared ownership and understanding by professionals of scope of practice and develop clear roles for all team members that support working to full scope of practice.
Limited confidence and professional isolation, particularly in rural and remote areas.	Place based models of education and support, including interdisciplinary professional development and supervision and utilisation of remote learning and decision support to lift skills and confidence.
National or state models of workforce and professional practice which do not fit outer metropolitan, rural or remote locations.	Supporting nationally but acting locally – Planning and development of agile place based models of multidisciplinary care which have flexibility to support optimal scope of practice to respond to diverse and changing consumer demands.
Funding models which do not support multidisciplinary care or incentives needed to enable providers to work to full scope of practice.	Harnessing available funding sources, including new federal Budget measures to resource and incentivise integrated team based models in which all members are supported to work to optimal scope of practice.

Key Focus Areas and the potential role of PHNs

Within the context of the above vision, PHNs offer the following comments in relation to the potential role of PHNs against the key focus areas identified in the Terms of Reference.

Leadership and culture – National, State and local leadership is vital to plan for service models which enable optimal scope of practice. At a local level, leadership by way of planning, clinical governance, and a commitment to quality and safety should underpin efforts to support multidisciplinary teams to work to full scope of practice. A collaborative culture embedded in joint workforce and service planning and co-design of models of multidisciplinary care is essential.

It is within the remit of the role of PHNs to build capacity within the primary care sector to support health care providers to work to full scope of practice. In partnership with Local Hospital Districts and other local stakeholders, PHNs can provide essential local leadership and workforce planning to promote optimal use of workforce. To do this, however, authority and clear policy support from state and Commonwealth governments is needed.

PHNs also have developed significant capacity in regional workforce analytics and knowledge of local community needs and services to inform planning. This includes initiatives such as the Workforce Planning and Prioritisation Program.

Funding mechanisms – Blended payments and targeted commissioning should be used to help to support professionals to work at full scope, particularly in failed or thin markets and to help with coordination, planning, workplace incentives and education and training.

PHN commissioning will play a vital role in resourcing local efforts to support the primary care workforce to optimally work to full scope, in addressing service gaps, and in planning ways to harness and supplement private primary care service delivery. PHNs can also work with local LHNs to explore opportunities for collaborative commissioning and co-design, if given authority to do so.

New workforce funding measures in which PHNs have a role, including MyMedicare GP initiatives, new funding for multidisciplinary teams, and trial initiatives to overcome thin markets can be

leveraged and rolled out in a way that ensures an expectation of professionals working to full scope of practice and inform appropriate models of care.

Education, training and collaboration – A commitment to continuing support to maintain skills, including appropriate clinical supervision is vital. Given the importance of place-based models of care, an emphasis on skill transfer from local professionals and on the job training should be a priority to support practical local realities of working to full scope of practice. Curriculum, assessment and standards for continuing education should be designed to support working to scope of practice and importantly, should be informed by the role of PHNs in the local primary care landscape.

PHNs have a role in supporting primary care providers to unlock their potential to improve quality and integration of care, and also to make optimal use of digital health systems. In commissioning services, PHNs can contractually require that services provide appropriate place-based training, skills transfer and clinical support. Through partnerships with LHNs and other local stakeholders, PHNs can also promote collaborative service provision, with shared outcomes and objectives.

Technology and digital support – In rural and remote areas, technological solutions to assist decision support, treatment, agile referral pathways, training and supervision, should be developed to address clinical isolation. Virtual decision support tools in particular will help ensure a consistent approach by all workforce to diagnosis and treatment.

PHNs are in a position to share best practice digital solutions and also to commission services which make optimal use of technology to support professionals to work to scope within the local service environment.

Legislation and regulation – Some population groups may be missing services because of unnecessary regulatory restrictions, particularly in settings such as residential care or remote areas.

PHNs are well placed, through needs assessment and workforce analytics, to identify gaps resulting from regulation and to identify appropriate local solutions. Priority should be given to identifying and promoting circumstances in which these restrictions can be relaxed and the protocols which should be in place to do so.

3. Response to Survey Questions with Reference to PHN Experience

A. Who can benefit from health professionals working to their full scope of practice?

Benefits for consumers – If health professionals are working effectively to their full scope of practice, consumers should stand to benefit by way of an improved patient experience and better outcomes, in line with the quintuple aim of healthcare. The benefits should be considered at a universal level, as all primary healthcare consumers should receive optimal care from their healthcare team, regardless of location.

However from a PHN perspective, some consumer groups stand to benefit more than others from efforts to support primary care professionals to work to their full scope of practice and should be targeted with measures to overcome barriers to enable professionals to optimise scope of practice. In particular, under-serviced groups with access to a limited range of health professionals by way of their location, their needs or cultural safety issues, should be targeted by measures to encourage or incentivise working to full scope of practice. This includes:

- People in rural or remote areas;
- People in other thin or failing markets – such as some outer metropolitan areas;
- Aboriginal and Torres Strait Islanders,
- Older people, including residents of residential aged care facilities.
- People with complex chronic or mental health conditions or comorbidities.

PHNs have substantial experience and local knowledge of working with these groups, particularly through their role commissioning services for people with mental health needs, chronic illness, or from underserved groups.

By authorising and upskilling professionals who work in remote areas to deliver diagnostic services which would not be otherwise readily available, early intervention can be achieved. For example in the Gippsland PHN, a nurse practitioner, with training in Advanced Dermoscopy and Advanced Skin Care medicine is delivering skin checks in Aboriginal Controlled Community Organisations, to help address poor survival rates from melanoma in these communities (See Case Study 1).

Benefits for Health Practitioners – If individual health practitioners are supported effectively to work to full scope of practice, they should benefit by way of clinician wellbeing, work satisfaction and improved autonomy. If a multi-disciplinary team is supported to work to scope, there can be cascading benefits. Pressure on other professional team members may also be relieved, and they also may be assisted to work to their full scope of practice, if changes in role are carefully planned, communicated and assessed in collaboration with all members of the team.

The capacity to undertake a task which is within scope but previously required referral to another provider, also frees up time for health professionals.

Practitioners who can benefit from reforms to better support working to scope of practice include GPs, nurses, nurse practitioners, mental health nurses and pharmacists, and other clinical members of teams funded through PHN commissioned activities including Aboriginal Health Workers, and allied health workers such as physiotherapists and psychologists.

Non-clinical members of a multidisciplinary team can also benefit from and contribute to work to scope arrangements. This includes assistant allied health workers, peer support workers and non-clinical administrative staff, who are able to take on the low impact/high administrative tasks. For example, in Murrumbidgee PHN, through a project providing primary care for people with high

impact chronic disease over winter, administrative staff were trained to undertake triage, freeing up nurses trained in spirometry to undertake outreach visits to monitor patients with COPD (Case study 2).

Case studies provided under the next section outline how these members of the workforce are able to support other team members to work to full scope of practice, including Allied Aboriginal Health Workers and Mental Health Peer Workers.

Benefits for commissioning agencies – PHNs and other local commissioning agencies could benefit from making more optimal use of available workforce resources within a multidisciplinary team environment, particularly where there are workforce supply issues.

Commissioning agencies can also benefit from the agility available from being able to optimise scope of practice and utilise capacity and skills to enable agile responses to disaster or emergencies, or during public health crises or pandemics.

For instance in response to COVID-19, a range of allied health professionals were up-skilled to provide vaccinations in supervised clinical settings, and mobile primary care clinics run by nurses and pharmacists provided outreach clinics in hard to reach rural communities.

Case Studies

Appendix 1. Nurse led skin care clinic in ACCOS – Gippsland PHN

Appendix 2. Primary care for people with chronic disease over winter – Murrumbidgee PHN

Key messages:

- *Whilst from an equity perspective, all consumers have the benefit of a primary care workforce able to work to full scope of practice, there is merit in ensuring that professionals working with underserved groups or in thin or failing markets are supported to extend to their full scope of practice to address unmet needs;*
- *In addition to key skilled professionals such as GPs, nurse practitioners, Aboriginal Health Workers and allied health professionals, opportunities should also be explored for supporting other non-clinical or assisting professionals to work to full scope of practice. This could include mental health peer workers, assistant allied health professionals, and medical practice assistants working in a team environment.*

B. How can these groups benefit?

PHN experience has demonstrated that working to full scope of practice can deliver more timely and effective care and make best use of the workforce if it is supported by a well-planned multidisciplinary team environment and well communicated policy and regulatory authority.

This can be achieved by encouraging and supporting all team members to work to optimal scope of practice in a coordinated way. Less skilled staff can be supported to take on low impact/high administration tasks. This then can free the capacity of more skilled staff to work to full scope of practice and offer a better patient experience.

This is illustrated through the Murray PHN's Nurse Practitioner Rural Outreach Model (Case study 7). This project used remote access to GPs to enable shared care by rural nurse practitioners, enabling them to maintain authority for full scope of practice within appropriate clinical support across a rural networked model including outreach sites. Basing the NPs in general practice enabled rural practice nurses and community health nurses on site to provide a wider scope of primary care services to

communities with otherwise limited access to GPs. This demonstrated the potentially cascading benefits of working to full scope of practice within a well-supported environment.

In the Northern Territory PHN, it has been demonstrated that Aboriginal Allied Health Assistants can contribute to a holistic, culturally safe and appropriate model of care with improved outcomes for clinical care and complex adoption of health and lifestyle modifications. This complements the role of Allied Health Professionals who work with them to deliver complex high-level care up to full scope of practice and supports enhanced clinical outcomes. (Case study 3)

Similarly, Brisbane North PHN has demonstrated how training non-clinical workers to provide peer support to people experiencing significant emotional distress in a Safe Space environment can deliver timely and de-escalating support to individuals and relieve pressure on hospital emergency services and traditional mental health support services. This service ensures that these peer workers are part of an extended team and supported by clinicians in other services, with provision for debrief and support, and that these clinicians are also trained and informed about the role of these staff. The interim evaluation has shown the role and perspective of peer workers is valued by clinicians and forms part of joint decision making. (Case study 4)

At COORDINARE - the South-East NSW PHN, an Osteoporosis Project demonstrated how addition of a Medical Practice Assistant (MPA) to a multidisciplinary team could enable all staff to work to scope of practice with appropriate training and supervision. MPAs were formally trained to perform a wide range of admin tasks and front desk duties as well as assisting with a wide range of treatment room procedures. They worked under supervision of a medical practitioner. MPAs working to full scope of practice facilitated time for the Practice Nurse (PN) to work to top of scope and increased PN and GP time for clinical support of participants. (Case study 5)

Case Studies

Appendix 3. Aboriginal Allied Health Assistants – Northern Territory PHN

Appendix 4. Safe Spaces – Brisbane North PHN

Appendix 5. Osteoporosis Project – COORDINARE-Southeast NSW PHN

Key messages:

- *A well-planned, multidisciplinary team environment is important to facilitate opportunity for all team members to work towards full scope of practice;*
- *A coordinated approach to defining team roles, delegation of tasks and supervisory arrangements, to support opportunities for working to full scope of practice will enable a cascading effect where all members are able to fully utilise their skills and offer a better patient experience.*

C. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice?

There are potential risks to patient safety and to providers of encouraging health practitioners to work to full scope of practice. In general, these can be mitigated through a well-planned and well-supported multidisciplinary team environment and through clear clinical protocol development.

Lack of support and or clinical protocols to deliver full range of services appropriately and safely –

From a PHN perspective, possibly the greatest risk of encouraging primary health care practitioners working with commissioned services to work to full or expanded scope is that integrated local systems might not be available and visible to offer the support and mandate needed to enable the individual professional to deliver services confidently, consistently, appropriately and safely. This could include:

- Lack of clear clinical protocols for delivery of all in scope services;
- Lack of professional supervision and clinical governance
- Lack of relevant and localised training and support
- Lack of multidisciplinary team support to offer necessary backup and support
- Lack of authority and a clearly communicated mandate to work to full scope of practice, particularly for professionals delivering services in locations with unmet need.

These risks and approaches to their mitigation are discussed further in the barriers section.

These risks could be amplified for professionals who are delivering services in remote locations where there is significant pressure to work to full scope of practice. It will be particularly important they are supported by way of resources, supervision, and a clear mandate in these locations.

Additional demands on professionals already under pressure - A further risk to working to full scope of practice which could be encountered, particularly in areas of scarce workforce, is that this could be perceived as an extra demand on professionals already under significant pressure. Models of care supporting working to full scope of practice must be developed and communicated as offering flexibility to work practices to address patient needs in a more efficient way, rather than adding to overall workload. In addition, mitigation must include co-design of roles with professionals to ensure realistic expectations of capacity.

A shift towards full scope of practice by one team member may result in gaps in lower scope activities if these tasks cannot be delegated – Whilst working to full scope of practice should benefit members of a multidisciplinary team, workforce planning should ensure other members of the team also work to full scope to pick up tasks which may need to be delegated. Case studies 2, 3 and 4 illustrate this.

In general, a shared and documented systemic commitment by governments and other local funders to supporting a multidisciplinary team model which optimises full scope of practice is also needed to mitigate against risk. This commitment should be by way of integrated and interoperable data systems, tools, supervision, training, coordination, de-briefing and clear clinical governance which articulates roles and responsibilities and referral pathways.

Key messages:

- *Risks of working to full scope of practice can be mitigated if appropriate protocols supervision, clinical governance, education training and multidisciplinary team support is available for all team members, including through virtual means.*
- *Working to full scope of practice must be communicated as offering flexibility to use skills to meet patient needs effectively, not adding to overall workload.*

- *Co-design of roles with all professionals within the team, and robust planning for top and bottom of scope tasks, will help to ensure that extending towards top of scope of practice by one professional will not result in gaps or additional pressures on team members.*
- *Risks for professionals in remote locations who are under significant pressure to work to top of scope given lack of service alternatives must be supported by appropriate authority and support.*

D. What barriers can government, employers and regulators address to enable health practitioners to work to full scope of practice?

From a PHN perspective, the most significant barriers include the following:

System level barriers

- Lack of authority and delegation to PHNs and other local bodies for joint regional planning, coordination and collaborative commissioning arrangements which can support new models of care.
- Rigid and short-term funding models, including a reliance on fee-for-service, and siloed government funding arrangements which restrict capacity to provide support and coordination to individual professionals.
- Lack of clear and consistent messaging from governments and professional bodies supporting primary care workforce to work to full scope of practice.

Service level barriers

- Limited availability of roles which promote working to full scope of practice.
- Lack of clear communication and understanding within professional teams and among patients about the full scope of practice of particular professionals.
- Local non-availability of core primary care team members, such as GPs, required for clinical back up, prescribing or supervision.

Provider level barriers

- Lack of professional training and confidence.
- Professional isolation and lack of confidence – including issues faced by small and solo general practices and individual professionals working in remote locations.
- Lack of team members to whom to delegate 'lower scope of practice' activities.
- Limited access to technology for diagnostic or decision-support and training.

These barriers have been well explored in literature relating to scope of practice of nurse practitioners. In particular, ambiguity surrounding the practice scope of nurse practitioners has been found to limit the profession's ability to fully respond to Australia's current and emerging health system challenges. Nurse practitioners have had to expend valuable time advocating or defending their role. Lack of availability of roles which optimise scope of practice has also been identified.^{5 6}

In Western Australia, the WA Primary Health Alliance (WAPHA) demonstrated how GPs could delegate lower scope of practice activity to social workers. Through this project, social workers

⁵ A study of macro-, meso- and micro-barriers and enablers affecting extended scopes of practice: the case of rural nurse practitioners in Australia. Tony Smith, Karen McNeil, Rebecca Mitchell, Brendon Boyle & Nola Ries, BMC Nursing, April 2019

⁶ Registered nurse scope of practice in Australia: an integrative review of the literature, Melanie Birks, Jenny Davis, John Smithson & Robyn Cant, Contemporary Nurse, Vol 52, no5. 2016.

appointed to the care team with GPs were able to work with patients and carers to address social determinants of physical and mental health, enabling GPs in participating practices to work to the top of their scope and provide team-based care (Case Study 6).

Another example of how PHNs can address these barriers comes from Murray PHN's Nurse Practitioner Rural Outreach Model (Case study 7), which highlights how barriers to working to full scope associated with lack of a local GP supervision and other challenges associated with remote service delivery can be overcome. This project used remote access to GPs to enable shared care by rural nurse practitioners, enabling them to maintain authority for a full scope of practice within appropriate clinical support. The outreach support of the nurse practitioners also enabled rural practice nurses and community health nurses on site to work to scope.

Case Studies

Appendix 6. Social workers in General Practice – West Australian Primary Health Alliance

Appendix 7. Nurse Practitioner Rural Outreach Model – Murray PHN

Key messages:

- *System level barriers include a lack of visible national or state authority for local joint workforce planning and commissioning, and the rigidity of traditional funding methods.*
- *Service level barriers include limited availability of roles which promote working to full scope of practice, particularly for professions such as nurse practitioners. They also include communication issues.*
- *Provider level barriers include lack of professional, training and confidence and professional isolation.*

E. What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice.

Governments, employers, regulators and professional colleges can all play a role in addressing barriers and enabling professionals to work to full scope of practice if they wish to do so. From a PHN perspective, potentially the most important enabler to achieve workforce change is a clear authorising environment from governments for local planning, led by PHNs, LHNs and other local funding agencies to make optimal use of available workforce and to support collaborative commissioning.

Key enablers, linked to barriers identified in the previous section, are as follows.

System level

- Authority from governments for PHNs and other local bodies to undertake joint planning and collaborative commissioning to develop models of care which support available workforce to work to scope and provide integrated multidisciplinary team support;
- National/state authority for planning and collaboration, including bilateral agreements, and regulatory frameworks;
- Key professional groups and local commissioning agencies should promote a culture shift towards a focus on stretching to meet patient need within full scope of practice rather than retreating to established professional roles;

- Blended payment funding systems to resource appropriate incentives for professionals to work to full scope of practice, as well as funding coordination, training support, and clinical supervision;
- Build new multidisciplinary teams which co-design and define roles for all team members to work to full scope through new Budget measures including Multidisciplinary Team funding, and trials being undertaken through the Supporting Health, Care and Support Services in Thin Markets measure.

The bilateral agreement for mental health and suicide prevention between the Commonwealth and States and Territories provides an example of a system level change to support integrated workforce planning and collaborative commissioning by PHNs and LHNs to enable professionals to work to full scope of practice, particularly in areas such as youth mental health.

A simple but effective model of collaborative commissioning by a PHN and LHN is the Diabetic Foot Care project led by the Northern Territory PHN. Through this project, a podiatrist jointly funded by the PHN and the LHN visits the clinic to upskill a local support worker, allied health providers and remote area nurses to work to full scope of practice to effectively manage the foot care of diabetics and prevent need for hospitalisation. (Case study 8)

Service level

- Co-designing and co-commissioning roles which involve working to full scope of practice within multidisciplinary teams in new measures and contracts, with appropriate clinical governance.
- Consistent communication within teams and communities about full scope of practice.
- Flexibility supporting working to full scope of practice in remote areas or failing markets.
- Building expectations of working to full scope into service contracts and job descriptions.
- Developing specific models of working to full scope of practice for teams supporting GPs manage mental health presentations, or other areas of high prevalence.

A practical example of co-commissioning to support GPs to work to full scope of practice is the Enhancing Paediatrics in Primary Care project led by Murrumbidgee PHN. Through this project the LHN and PHN jointly funded a paediatrician to build capability among GPs and other primary care providers. This support also ensures standardised screening, assessment and referral and offers continuing professional development to GPs. The paediatrician also participates in multidisciplinary primary care clinics. (Case study 9)

The Safe Spaces project at Brisbane North PHN has also demonstrated how co-design and communication with professionals in other agencies on workforce roles intended to promote working to full scope of practice by mental health peer workers, has enabled professional support and respect for these roles. (Case study 4)

A further case study at Healthy North Coast PHN illustrates how pharmacists can work with triage nurses and GPs in a model of care which enables pharmacists to work to full scope of practice supporting GPs to provide digitally enabled after hours care for people with respiratory conditions, dermatological issues and mild to moderate pain. (Case study 10)

Provider level

- Planning roles within a multidisciplinary team context to ensure complementary changes within other roles in the team and to enable team support and skills transfer.
- Promoting availability of education and training, including locally based, 'real time' on the job support and where appropriate, virtual training to work to full scope of practice.
- Better utilisation of non-clinical staff and assistants to whom to delegate lower level activities and administrative tasks.
- Harnessing available technology.

In Gippsland PHN, a nurse-led remote monitoring and virtual care coordination project, targeting the needs of people with chronic disease in remote locations has demonstrated the use of technology to support clinical decision making needed to enable working to full scope of practice. The Remote Patient Monitoring (RPM) platform has supported virtual monitoring and care coordination by nurses for patients unable to easily access GPs and supported timely interventions to prevent hospitalisation (Case Study 11).

In the ACT, Capital Health Network (CHN) has utilised pharmacists as members of the multidisciplinary team providing services to residents of residential aged care facilities to help address the problem of inappropriate medication. CHN funded part-time pharmacists working to their full scope and providing education, medication reviews and contributing to organisational policies and procedures (Case Study 12).

Finally, it is worth considering the success and agility with which arrangements were put in place to support health care providers to work to scope during the height of the COVID-19 pandemic, as previously mentioned in this submission. The enablers at a system, service and provider level which supported this are worth further analysis as part of the review, including the authority and commitment to collaboration which provided a foundation for working to full scope of practice.

Case Studies

Appendix 8. Diabetic Foot Care – Northern Territory PHN

Appendix 9. Enhancing paediatrics in primary care – Murrumbidgee PHN

Appendix 10. New digital front door to primary care – Healthy North Coast PHN

Appendix 11. Nurse-led remote monitoring and virtual care coordination – Gippsland PHN

Appendix 12. Pharmacists in Residential Aged Care Facilities – Capital Health Network

Figure 2 - The relationship between key barriers and enablers

Barrier	Enabler
Lack of an authorising environment for full scope of practice and for local planning – ambiguity about boundaries	Clear ‘top down’ authority and messaging from governments, Colleges and funders to give confidence and clarity to multidisciplinary teams.
Lack of ongoing education, training and support	Access to education and training support through team, virtual support or decision support tools
Lack of local planning and coordination within an authorised environment	Joint local planning, led by PHNs or other regional authorities, with the backing of state or national authority, to plan for opportunities to optimise working to full scope of practice and for supporting team environments.

Funding models which do not offer support for education, coordination, or clinical supervision.	Commissioned services and blended payments to supplement fee for service and traditional funding mechanisms.
Culture within local workforce and services focuses on professional silos and traditional roles	Shift in culture to focus on patient need and on ways to support available workforce to address need.
Professional isolation and lack of confidence in working to full scope of practice.	Multidisciplinary team environment

Key messages:

- *A clear authorising environment from governments is needed for local planning, led by PHNs, LHNs and other local funding agencies to make optimal use of available workforce and to support collaborative commissioning.*
- *New Budget measures including Multidisciplinary Team funding, and trials being undertaken through the Supporting Health, Care and Support Services in Thin Markets measure can be harnessed to help build new multidisciplinary teams which co-design and define roles for all team members to work to scope.*
- *Available technology to provide diagnostic or decision support, enable on the job training, or facilitate remote team work should be promoted and where necessary adapted to meet different local needs.*
- *The enablers at a system, service and provider level which supported the agile response to Covid-19 are worth further analysis as part of the review, including the authority and commitment to collaboration which provided a foundation for working to full scope of practice for a range of professions.*

Appendix 1. Clinical Nurse Consultants delivering regional skin checks in ACCOs – Gippsland PHN

Identified Need

Gippsland PHN received a request from an Aboriginal Community Controlled Organisation (ACCO), to support a Skin Clinic for the local community.

This aligned with a data which demonstrated that Aboriginal and/or Torres Strait Islanders peoples in Victoria have a five-year survival rate of 59 per cent after being diagnosed with melanoma compared to 71 per cent for non-indigenous Victorians.

Approach/Activity undertaken

Following consultation and collaboration, Gippsland PHN commissioned a mobile skin check clinic provider to visit all six Gippsland ACCOs.

The provider's lead clinician is a Qualified Clinical Nurse Consultant and Nurse Practitioner with diplomas and post graduate certificates in Advanced Dermoscopy and Advanced Skin Cancer Medicine, with more than 10 years working in the field of Melanoma and skin cancer. The mobile skin check clinic provides a risk stratified approach ranging from short check-ups for a small number of spots/moles to total body photography.

Outcomes

The earlier skin cancer is identified and treated, the better chance of avoiding major treatment or serious Melanoma or skin cancer and the resultant impact on potential life expectancy. Prevention and early detection, with patients receiving follow up, if required, combined with data sharing with the ACCOs will support monitoring of any identified concerns over time. The workforce model of utilising a clinical nurse consultant was a key success factor in a rural/regional area with limited access to specialist dermatology/skin cancer services.

Appendix 2. Primary care initiatives to support people with chronic disease over the winter period. – Murrumbidgee PHN

Identified Need

The Murrumbidgee region has some of the highest rates for potentially preventable hospitalisation, especially for people with COPD and Congestive Heart Failure. We have inconsistent levels of services across the region, limited access due to distance and limited transport options, cost barriers and extensive wait times. This is especially true for access to specialists and investigations for the purpose of diagnosis.

Approach/Activity undertaken

Following consultation with more than 200 stakeholders in our region, the *Living Well, Your Way* (LWYW) Care Pathway was designed. The pathway outlines seven stages from prevention and screening through to optimal care in the community. Each stage brings together a range of healthcare professionals to support people living with COPD and CHF to navigate their health journey, but also to improve screening and early access to diagnosis. As part of the LWYW initiative, Murrumbidgee PHN and the Murrumbidgee LHD have had a focus on supporting practice nurses to work at the top of their scope.

Outcomes

38 general practices were commissioned to participate in the LWYW Winter Strategy for 2023. Participation in the program has required the general practice team to provide additional proactive support for patients over the winter period, training in chronic disease management plans, MBS billing, and spirometry training. 22 nurses participated in spirometry training and over 30 administrative staff participated in triage training for non-clinical staff. The program is in its final stages of reporting.

Appendix 3. Aboriginal Allied Health Assistants – Northern Territory PHN

Identified Need

There is an increasing demand for allied health services in Central Australia, as Aboriginal and Torres Strait Islander community members in this context are disproportionately affected by the complications associated with chronic disease. The largest growth area in the Aboriginal Community Controlled Health Services workforce in recent years has been in allied health.

Aboriginal Allied Health Assistant (AAHA) workforce can contribute to a holistic, culturally safe and appropriate model of care with improved outcomes for clinical care and complex adoption of health and lifestyle modifications. The Allied Health Professionals are able to compliment the role of AAHA with complex high-level care at top of scope for enhanced clinical outcomes.

Approach/Activity undertaken

A new activity, supported through the Commonwealth Governments Primary Health Networks Aged Care Funding is establishing AAHA workforce working in a 'bi-cultural pairing' with Allied Health Professionals to support senior community members.

Outcomes

While this activity is gaining momentum, the AAHA are building capacity to provide lower risk, day to day allied health supports under the supervision of the Allied Health Professionals in culturally responsive and trusted care to communities. The longer-term outcomes are anticipated to be evidence aligned with Closing the Gap intentions.

Appendix 4. Safe Spaces – Brisbane North PHN

Identified Need

The need for Safe Spaces in the Brisbane North region emerged from research undertaken by the Partners In Recovery (PiR) program in 2016- 17. This was followed by two Safe Space trials in the region in 2018- 19 through Metro North Health LINK funding. Based on this trial and in collaboration with local mental health services, Brisbane North PHN then applied for funding to continue this program in 2019. Funding was received and contracted for service delivery from June 2021– June 2024. The funding received was for 4 Safe Space sites and a regional network coordinator.

Safe Spaces provide an alternative to hospital emergency departments for people experiencing emotional distress. They are majority-staffed by peer workers with some clinical oversight and governance.

Approach/Activity undertaken

Once CHHP funding was received, Brisbane North PHN engaged Roses in the Ocean, a lived experience organisation, to develop and deliver the co-design process to shape the model of service. The draft model of service delivery was developed using a consultative process with lived experience representatives and health service providers in the respective catchment areas of North Brisbane. The co-design process showed that people experiencing emotional distress wanted the Safe Spaces to be 'peer-led' i.e. to be run by people with their own lived/ living experience of emotional distress.

Brisbane North PHN has engaged Nous to conduct a three-year evaluation of the Brisbane North Safe Spaces. The [first interim evaluation report](#) was received in 2023. For the purposes of this case study, the following points have been highlighted:

1. Peer workers: the peer perspective is valued and forms part of joint decision making with clinicians, regardless of whether operations are managed by peers or clinicians
2. Developing a specific model of care: there is no 'roadmap' for implementing this type of service. The report found that the collaborative approach between the PHN and commissioned service providers to establishment has supported effective implementation
3. Staff training: the report recommended expanding and pooling training resources across all Safe Spaces sites and for all levels of staff.

Outcomes

Following the release of the first interim evaluation report, Brisbane North PHN in collaboration with the Safe Space service providers, are –

1. Continuing to review the Safe Space model governance model to ensure that the co-design results of 'peer-led' Safe Spaces is being adhered to, whilst balancing the need for clinical governance
2. Developing clearer guidance on the service model and will crystallise guidance and messaging on the target cohort without creating rigid exclusion criteria.
3. Engaging Brook RED, a lived experience organisation, to provide a wide range of training opportunities for Safe Space staff to increase consistency, upskill staff and promote a community of practice to aid burnout. The majority of this training is for the peer workers however some is also available for management and clinicians. It is anticipated that this training will reduce attrition, address burnout and improve job satisfaction.

Appendix 5. Reframe Osteoporosis Project: Role of the Medical Practice Assistant in Primary Care in Rural NSW – Coordinare SENSW PHN

Identified Need

In 2017 it was estimated there would be 155 fractures each day among older people in NSW and ACT. The estimated associated cost was \$1.1 billion for osteoporosis and osteopenia, and \$740 million for related fractures. ([*Burden of Osteoporosis, Osteopenia and Associated Fractures in NSW and ACT – 2012-2022 Sanders, Watts et al.*](#))

Osteoporosis is a rarely identified chronic condition with 2 out of 3 Australians aged >50 years having osteoporosis and osteopenia. 55% of the Marima Medical Clinic demographic was over 55 years of age.

Approach/Activity undertaken (Heading 4)

In 2017, SE NSW PHN funded the Reframe Osteoporosis project as part of the [Patient Centered Medical Home Project](#). Small groups of up to 12 patients were established, with 3 sessions provided involving a GP, Practice Nurse (PN), Dietitian, Exercise Physiologist and Medical practice Assistant (MPA). The model focussed upon all staff working to top of scope, with a particular focus on the introduction and establishment of 3 MPAs. MPAs are formally trained to perform a wide range of admin tasks and front desk duties as well as assisting with a wide range of treatment room procedures. They work under either the direct or indirect supervision of a medical practitioner and carry out a range of delegated tasks that include front desk administrative work and the performance of instructed treatment room care. MPAs were responsible for inviting patient to participate in the program, assisting with set up, greeting patients, and recording height, weight, smoking status. MPAs working to extended scope, facilitated time for the PN to work to top of scope and increased PN and GP time for clinical support of participants.

Outcomes

The project utilised various evaluation methods, including patient surveys, practice data statistics, feedback from patients and staff, clinical audits, and discussions with the team. Results showed significant improvements in bone mass density screening for osteoporosis, with increased awareness in identifying eligible patients. The results from the patient survey demonstrated the project's success in engaging patients in their health education and in empowering them to take control of their health.

The results suggested more seamless integration of MPAs could have been supported through education of nurses about the role of MPAs. Despite this, the overall benefits of embedding MPAs in the workflow was recognised. To optimise their roles, a further extension of their scope was proposed with suggestions focussed on screening, organisation, and coordination of patient care. It was felt MPAs could play a key role in the planning of shared medical appointment sessions, telehealth consultations, tele psychiatry as well as coordination of patient care.

The project also highlighted the benefit of incorporating allied health to provide preventative health initiatives. Further information regarding the role of allied health can be found in this [case study](#), [model of care](#) and [short video](#).

Appendix 6. Social workers in general practice -Western Australia Primary Health Alliance

Identified Need

Codesign workshops with practices identified that GPs were spending increasing amounts of time addressing social determinants of health for large numbers of patients and their carers. They recognized they did not have the expertise or time to address the issues.

Approach/Activity undertaken

Social workers, as part of the care team, worked directly with patients and their carers to address social determinants of health and complex psychosocial issues. This was to enable general practitioners and clinicians in participating practices to work to the top of their scope and provide team based care. The program used measures across the Quadruple Aim.

Outcomes

Positive patient experience - needs being met and improvement in sense of well-being – 94% Highly Satisfied; 94% Improves care; 96% would use the service again. Patient Reported Outcomes Measures consistent improvement over eight domains – Lifestyle, Looking After Yourself, Managing Symptoms, Work and Activities, Money, Where you live, Family and Friends, Feeling positive. Increased linkage to community services by 250%

Positive practice staff experience – 83% staff reported SW service positively impacted on team based care; 75% reported the holistic needs of the patients were supported including MDT care planning and case conferences; 90% of practice staff reported increased confidence dealing with patients with complex psychosocial needs; 85% reported increased capacity of the practice to manage the healthcare of complex patients; 68% reported a positive effect on GP staff emotional wellbeing and less emotional energy expended with 'heart sink' patients with more time reported to deliver medical and nursing care.

Link to references

<https://outcomesstar.com.au/> - PROMs tool used

<https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=80160&qt=ItemID> Mental Health Accredited Social Workers and MBS

Appendix 7. Nurse Practitioner Rural Outreach Model – Murray PHN

Identified Need

Body Text (Normal) Murray PHN identified the need for new multidisciplinary team model working at broader scope to deliver on community need in thin market region of north central rural Victoria, specifically to provide access to high quality services in ageing and chronic disease.

Approach/Activity undertaken

Body Text (Normal) Murray PHN co-designed the model with a network called the Integrated Health Network (IHN) Alliance. Our Project Coordinator applied sustainability principles, and used co-design methods and participatory evaluation to ensure the model would allow learning and refinement to expand scope for better access, and interest and viability of the practices. The model is now embedded in a range of solo general practices for expanded scope of practice for GPs, Nurse Practitioners and Care Coordinator, through The Nurse Practitioners and Care Coordinators work with GPs, outreaching to others site, and their role in the team enables the GPs to focus on the most complex cases.

Outcomes

GPs and Nurse Practitioners and Care Coordinators all work at broad scope and enjoy the role and practices have embraced the model with clear referral and backup systems for broad scope.

The model has improved MBS revenue billed to three GP clinics.

Consumers Strong demand from the community - in 4-6 months of the pilot, 262 consultations have been delivered across 32 clinic days.

- Over half of the patients using the service found out about it at reception at the time of booking, whilst a further 21% of patients heard about the service by local word of mouth.
- 64% of surveyed participants stated they would have to had waited to see a doctor if it weren't for the service but the wait times for the doctors can be lengthy.
- 3% would have gone to hospital.
- Practice revenue from MBS has been around \$400 per clinic day and the GPs are enjoying the potential to refer patients to another primary care provider for back up, and have time off when they need it.
- More than 95% of participants agreed they were satisfied with the service provided.

Appendix 8. Diabetic Foot Care – Northern Territory PHN

Identified Need

Diabetes is one of the fastest-growing challenges in the NTPHN region. The disease burden and its cost to the communities based on socioeconomic, gender, racial and ethnic status are high.

- In 2020, the incidence of insulin-treated diabetes type 1 incidence across all ages in the NTPHN region was 11 per 100,000 people.
 - 62% were males compared to 38 females.
- The incidence of insulin-treated diabetes type 2 was 1,547 per 100,000 people.
 - 60% were males compared to 40% females.
- Research evidence indicated that the burden of diabetes in the remote Aboriginal populations in the NTPHN region is one of the highest in the world.

There is an ongoing need to collaborate with Aboriginal communities to develop a holistic approach to addressing the wider social determinants associated with the increasing diabetes prevalence.

Approach/Activity undertaken

Funded under the Medical Outreach Indigenous Chronic Disease Initiative, Podiatrists visiting remote Indigenous communities are upskilling the local support worker, Allied Health Practitioners and Remote Area Nurses at full scope, to identify and address foot care needs in communities with complex social environments, often with complex comorbidities and low service provision

Outcomes

With greater skills available in place-based care, foot care is supported by the resident workforce and the need for specialist assessment and treatment is prioritised to those with much higher needs. Visiting Podiatrists are therefore able to concentrate efforts on more complex needs and diabetic patients with high-risk foot conditions.

Appendix 9. Enhancing Paediatrics in Primary Care – Murrumbidgee PHN

Identified Need

Children in rural communities, particularly the Murrumbidgee region of NSW, experience great vulnerabilities and poorer health outcomes. This is exacerbated by the lack of access to appropriate screening, assessment and treatment services.

Approach/Activity undertaken

In 2019 MPHNS in collaboration with the Murrumbidgee Local Health District launched the Murrumbidgee Maternal and Child Health Strategy which provides an agreed regional approach to improving maternal and child health outcomes in the Murrumbidgee region. The Strategy identified there was a need to strengthen the existing workforce by increasing the expertise and confidence in paediatrics to try and ensure appropriate use of hospital based resources and increase the uptake of child health screening for those requiring specialised support. The Enhancing Paediatrics in Primary Care model was subsequently codesigned with consumers and health care providers. The model focusses on the children aged 0 – 7 years of age.

Outcomes

The Enhancing Paediatrics in Primary Care includes a number of components aimed at ensuring the primary care workforce is operating at top of scope, and includes the following elements:

Community Paediatrician

- Joint funded Community Paediatrician with the Murrumbidgee PHN and Murrumbidgee LHD; focus is to develop capability within primary care.

Primary care enhancement:

- Standardised screening, assessment, and referral tools
- Community paediatrics consultation support (email/telehealth)
- HealthPathways, including family education resources
- Continuing professional development

GPs with Special Interest:

- Four GPs engaged to develop expertise and run specific clinics to identify behavioural and developmental issues in children aged 0-7 years.
- Engagement in monthly codesign meetings with the Community Paediatrician, LHD Child and Family Health Nurse and Allied Health provider
- Enhanced training opportunities
- Supported case conferencing between GP and Community Paediatrician
- Multidisciplinary clinics including allied health and Community Paediatrician (email, telehealth, case conference) for initial assessments.

WARATAH for Kids:

- The WARATAH for Kids program aims to increase the uptake of developmental and behavioural screening in general practice via appropriate pathways and provide therapy on a case-by-case basis. The PHN commissioned provider delivers both speech pathology and occupational therapy clinics linked with the GPs with Special Interest across the four communities. Follow up case discussions are held between the Community Paediatrician, the GP and relevant practice nurse and/or child and family nurse, and allied health provider to determine appropriate management plans. Nine clinics have been held since April 2023 with 20 kids screened and appropriate management plans and referral provided.

Appendix 10. New digital front door to primary care Healthy North Coast PHN

Identified Need

On the North Coast of NSW, low urgency presentations to EDs by those aged 15-24 years are amongst the highest in the country, with presentation rates higher for Aboriginal people. Low urgency presentations for young people are highest in the areas of Kempsey, Clarence, and Richmond Valleys

Approach/Activity undertaken

As well as extensive data analysis, a series of codesign workshops were undertaken with consumers, GPs, allied health professionals, nurses, Local Health Districts (LHDs), Aboriginal Medical Services, national subject matter experts and potential future providers, to understand the issues and elicit potential solutions for new innovative approaches to primary care access.

Two dominant themes emerged: technology enabled care and improved access to same day care, which led to the commissioning of North Coast Health Connect (NCHC). Launched in late 2022, NCHC, delivered by Amplar Health, Pharmaceutical Society of Australia, local general practices and community pharmacies, provides 24/7 registered nurse triage via phone or webchat that has the innovative functionality of being able to book quarantined general practice and community pharmacy appointments. The inclusion of community pharmacy as a referral outcome is a first in Australia.

Outcomes

Since commencing, NCHC triage nurses have received approx. 6000 calls/webchats.

Approximately 100 Pharmacists, from 26 participating NCHC pharmacies are involved in delivering this service. 50% of the services' integrated pharmacy bookings have been on weekends and afterhours, highlighting the unique offerings Pharmacists can play in providing primary care access, during and outside normal business hours.

Participating NCHC pharmacists work within their scope of practice, respiratory conditions such as coughs and common colds, dermatological issues, gastrointestinal problems such as constipation or diarrhoea. Other ailments may include mild to moderate pain such as headache, or strains and sprains.

The inclusion of community pharmacy is novel and ensures people receive care at the right level within the primary health care system. As a result, consumers do not take up GP or ED appointments, allowing people with more urgent conditions to access this care when they need it.

Appendix 11. Nurse-led remote monitoring and virtual care coordination – Gippsland PHN

Identified Need

High levels of chronic disease lead to preventable hospitalisations. There has been limited progress addressing longstanding structural challenges including access to health services, and fragmented service coordination. Health workforce shortages have highlighted the urgent need for new approaches to assist the community.

Approach/Activity undertaken

Gippsland PHN have commissioned a general practice pilot to fund practice nurse delivery of care coordination activities virtually through nurse led remote patient monitoring (RPM). Nurses, in consultation with general practitioners, are monitoring patients with chronic health conditions to undertake regular home based monitoring and provide access to comprehensive clinical decision-making and care coordination. The RPM platform allows real-time patient-health provider connectivity via a mobile app for patients, and a desktop application and mobile app for health practitioners in general practice.

Monitoring is mobilised through patients regularly reporting health and wellbeing information utilising clinically developed monitoring templates. Information reported outside a threshold generates an alert which the nurse then actions virtually which enables timely intervention. This nurse led model of care offers rural health services an innovative approach to prioritising and responding to the chronic care needs of their patients.

Outcomes

In the past 12 months, 133 patients and 5 carers have reported 64,816 vital signs and outcome measure via the platform. There have been 1,468 clinical alerts generated due to signs and symptoms being outside of thresholds, with 54 resulting in immediate follow up of the patient through a phone call or telehealth appointment. Practice nurses can further use the KPI dashboard to track patient cohorts and identify opportunities for improvement. A KPI dashboard which will allow practices to track patient care outcomes is under development.

Appendix 12. Pharmacists in Residential Aged Care Facilities – Capital Health Network

Identified Need

95% of residents living in Residential Aged Care Facilities (RACFs) have medication related problems with over 50% taking a potentially inappropriate medicine. 20% of RACF residents take antipsychotic medicines. 18% of unplanned hospitalisations are potentially due to inappropriate medication. The Royal Commission into Aged Care Quality and Safety has highlighted problems relating to medication management and has made several recommendations, including increasing access to allied health professionals, including pharmacists. In Australia, there is a growing recognition that a more integrated approach for pharmacists' involvement in RACF residents' medication management is required.

Approach/Activity Undertaken

CHN funded on-site pharmacists to be employed on a part-time basis by residential aged care facilities for 12 months to conduct a range of medication management activities including education, clinical audit, medication reviews, vaccinations, medication round optimisation and contributions to organisation policies and procedures. The pharmacists worked as part of the facilities' care teams, working and collaborating with residents, family members, carers, general practitioners and other prescribers (nurse practitioners, geriatricians, and other specialists), allied health professionals, and community and hospital pharmacists. Capital Health Network commissioned the University of Canberra to undertake a program evaluation.

Outcomes

Having an onsite pharmacist at RACFs:

- Reduced the proportion of residents taking potentially inappropriate medicines;
- Reduced the anticholinergic drug burden of medicines prescribed for residents;
- Reduced the dose of antipsychotic medicines prescribes for residents;
- Established positive working relationships with staff, residents and families;
- Successfully implemented and established as part of routine practice.

As part of the program, resources have been developed to support integration of pharmacists in RACFs.