Submission No 96

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO CROSS-JURISDICTIONAL HEALTH REFORM AND GOVERNMENT CONSULTATION WITH REMOTE, RURAL AND REGIONAL COMMUNITIES

Organisation: Inverell Health Forum

Date Received: 15 November 2024

From: Wendy Wilks [redacted]
Sent: Friday, 15 November 2024 12:30 PM
To: SC on Remote, Rural and Regional Health
Subject: Updated and added 1 page to attachment Submission Portfolio Committee No 2 recommendations relating to cross-jurisdictional Health reform
Attachments: Submission Draft to SC crossjurisdictional November 24.docx; The Inverell Health Forum Basic Business Case(002).docx; LIC Program Maree Puxty.pdf; Working together HNE and Inv Medical.pdf

[redacted]

Dear Dr Joe

We have sent a submission just now but we have omitted one page so if you would kindly take this as the updated submission. One of the attachments had1 page not included and is explanatory...

Once again we really appreciate the opportunity to submit to your Committee and we value this.

Please find our information attached and we look forward to being able to move forward with solutions eventually😊
We attach our Basic Business case which has been presented before and we hope to pilot in Inverell with interest and funding from Federal PHN or State Department
We attach the LIC program we have mentioned before and is really successful which could have really positive results ongoing and expanding.
We attach just some of the good news of our efforts to work with the providers of services in our area and our desire to be collaborative in achieving results.

Should you see any way we can further assist the Inverell Health Forum is happy to help and support in the changes endeavouring to be made

Many Thanks & Kind Regards
Cr Wendy Wilks
Convenor
Inverell Health Forum

[redacted]

[redacted]

Submission to**: Select Committee on Remote, Rural and Regional Health**
Parliament of New South Wales

Made by: Inverell Health Forum
Inverell NSW 2360
15th November 2024

Inquiry into the Implementation of Portfolio Committee No2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities

Please note: The first 2 pages of this submission are repeat introduction and history to give an overview to those who haven't knowledge of our Forum… We appreciate the opportunity again to submit to you again and will continue to do all we can for the people of our disadvantaged town. Our aim and objectives remain and our suggested solutions attached.

Inverell Health Forum:
The Forum is an Inverell community initiative, supported by Inverell Shire Council and chaired by Cr Wendy Wilks, comprised of councillors, general practitioners, medical practice managers, Aboriginal health service providers, representatives of business and industry, and community members that convenes for the purposes of furthering the aims and objectives described below.

Aim:
The purpose of this submission is to share practical recommendations and strategies to improve the quality of healthcare for Inverell and all rural and regional communities, resulting in timely health outcomes similar to those experienced in metropolitan areas.

Objectives:
• Improved health outcomes for Inverell, and rural and regional communities generally, through increased provision of both public (hospital) and private (general practice) medical services at a local level.
• Increased consultation on healthcare policymaking, so that practicing local rural health professionals and their communities have a say in decisions that directly impact them.
• To see members of rural and regional communities obtain primary healthcare equity within a reasonable distance of their residences, in line with metro area norms.

Background: Situation as per our original submission and updated progress following P 3
Inverell Shire is a vibrant community of around 18,000 people, which boasts a strong economy, thriving industry, and a growing population.1
The development of a new $60 million hospital completed in 2021 came with the promise of two equipped operating theatres and adequate staffing levels to ensure patient care for Inverell's residents and remove the need for frequent travel to larger centres.

Unfortunately, this outcome has not eventuated, with the level of healthcare declining over many years through the reduction of services at the Inverell hospital, along with an increasing shortage of general practitioners.

The Inverell hospital is often without a doctor on duty, and ambulance resources and skills are wasted on transporting patients to other towns; an estimated 480 non-emergency patient transports from Inverell occur annually. Transporting a patient to Armidale removes an ambulance from Inverell for a minimum of four hours, and transport to Tamworth involves six hours of ambulance time. The community is at risk due to the lack of available ambulance services during these transports. Patients whose care is deemed non-urgent are expected to arrange their own transport for treatment, causing extra physical and emotional stress, as well as isolation from family and financial hardship. Travelling a three-hour return trip for treatment that should be available locally is an unreasonable expectation.

The critical shortage of general practitioners also means Inverell residents are unable to access basic healthcare services, such as an appointment with a doctor, causing great distress and adversely impacting their quality of life. This also affects the health and wellbeing of the few GPs we have, as they have taken on extra, unsustainable workloads. The very real risk of burnout will further reduce the number of GPs practicing in our community, and makes recruitment of new GPs highly challenging.

Inverell doctors are currently restricted by hospital rating policies on the procedures they are allowed to perform, even when they have the required qualifications and experience. Patients are routinely required to travel by road for three hours or more – often at great physical discomfort and/or real risk to their health (e.g., in late pregnancy and/or in early labour) – when a very capable doctor is available and willing to perform a procedure at the Inverell hospital.

Inverell residents need and deserve more than a referral hospital. The lack of reasonable access to basic healthcare is far more than an inconvenience for communities like Inverell. In reality, for many people it is a life-or-death matter. Because primary healthcare is often not locally available, many residents postpone seeking medical attention, knowing it will in all likelihood mean travel and isolation from family and familiar surrounds. Sadly, in some cases this delay means help comes too late. We have been given to understand that the DOA (“dead on arrival”) rate at Inverell hospital is allegedly the highest in the state.

There is also a disconnection between the decision makers and the communities they are intended to serve. Policies based on external considerations and/or preconceived ideas of what rural and regional communities need – with little or no direct consultation – have serious implications for these communities.

Inverell residents conveyed their many concerns to members of the Inverell Shire Council, resulting in Cr Wendy Wilks forming the Inverell Health Forum to identify issues and try to find solutions for the healthcare crisis in our community.

In identifying shortcomings in the healthcare available to Inverell residents, it was seen that many other rural communities face similar issues. This healthcare crisis requires action, not just at a local level, but also through state and federal government intervention.

Question 1

Cross Jurisdictional cooperation between New South Wales and Australian Governments, in particular:

(a) Long-term strategic planning to improve health services and health outcomes in remote, rural and regional areas, including in relation to primary health (including Recommendations 1,7,8,and 11)

- To minimise the gaps in funding of smaller hospitals we suggest Block Funding to be granted from Federal/State Government. This is covered in our Business Case attached and to achieve our goal of equity of health for all Australians no matter where you live we suggest potential solutions.

- Having one Training supervising Dr in Inverell Hospital as in QLD would give primary health care to Inverell residents in Hospital and could advance the expansion of the LIC program (see attachment). This has been piloted with University of Newcastle and New England and is showing excellent results. Students in the program are 75% returning to Rural and Regional areas.

- Complete the final years of training in Rural and Regional areas is the secret to securing long term Rural Regional workforce. When the post University qualification years demand that the students return to major hospitals in cities to complete training they largely stay in that location. Eg Obstetrics, Emergency and Anaesthetics all demand the advanced skills training for Rural Generalists and currently must be done in Major centres. The Hub and spoke model is used effectively in QLD . Students comment on the large variety of activity in Country Emergency Departments which enables close to action experience. In the large Hospitals in the city they are part of a large team of Drs.

- There is no pathway for Rural Generalist trainees to complete their training in Rural Centres in NSW. They need to go back to a Referral hospital to be trained fully in the country. This is where and why the major loss of trainees and registrars occur. There is ample data of this from joint colleges and tripartite groups eg ACCRM RACGP RANZCOG.

- We have major centres prepared to work with us …however these are outside our LHD sometimes and utilising this **cross jurisdictional and cross border element would benefit immensely**. **Inverell could utilise closer locations like Lismore and Coffs Harbour and even Toowoomba in QLD.** The LIC program switches that outcome. Rural Hospitals need the ability to do the majority of the training locally and go to the Hub for a short intense period. Allowing weekly training on site in the locality with a Rural Generalist supervisor would mean a training pathway for Rural Generalists. Utilisation of Zoom or Telehealth can also be incorporated but not relied on as the only training aid.

- Federal Government pilot the Implementation of a regional coalition of Drs qualified in Anaesthetics, Obstetrics and Emergency who guide the new recruits in the LIC program to become Rural Generalists in Inverell, Moree and Glen Innes. This would mean Drs can operate across State Hospitals in areas of emergency or need and across Primary care and secondary care with Hospital based supervisors. This would also mean the 40,000 people in that area could have access to qualified Drs to administer health care on site and alleviate the inconvenience, cost and need to travel.

- Drs of this calibre in hospitals creating training in a smaller area. This is almost happening in Narrabri with a Dr in the Hospital fulltime and is funded by UNE and State Government.

- State Government could wind back and cap the amount paid to locums urgently. Also sharing coastal, city and bush in the rotation of choice.

- Many Rural locations are not consistently provided with Locums to meet the needs of the community. When the rate of pay increases for fulltime Drs in the Hospitals, and decreases for Locums, we should see a levelling and stability in service provision and cost saving. With not enough workforce it can necessitate a situation like going from Bathurst to Bondi to deliver a baby.

- Expand LIC student intake and training as mentioned above.

- Encourage the LIC students and continue the RDN student reconnaissance visits and the Bush Bursary which are all helping and the response from students is positive.

Question 2

Collaboration between NSW Health and Australian Government bodies on particular initiatives, services or training programs (inc Recommendations 9, 10, 14, 21, 22 and 39)

- We refer to our above pilot of integrating with the SEM but achieving training in the Rural Regional area. Once again, going back to the city, means we lose our workforce.

- Our Business Case is attached and has been previously presented. To be a pilot in Inverell Hospital and employ a Staff Specialist with permissions to allow Drs to perform to their qualification, and the hospital to hold stock to allow the work to proceed. Permissions to allow VMO Drs to perform to their qualifications, and not as currently restricted, would mean primary care is provided equally as is legislated. Arbitrary Hospital delineations restrict rural generalists capacity to work to the level they are

qualified therefore NSW is less attractive for rural Generalists. Local Drs drive productivity and that shows up the reduction in costs. (see Basic business case)

Our pilot offer is simple ……Employ a supervisor in Inverell Hospital to educate undergraduates from Years 3 - 5 and supervise junior Drs/CMOs on the Rural Generalist pathway locally to completion.

- Consideration of the HECS reduction for "places of need placements" not relating to MMA but actual reality. Staying in a Rural Regional Remote location for 2 yrs reduces by 40% and then after 5 yrs totally paid out. Provide a higher tax rebate or lower tax rate for locations of need for private practices. We are also to be working with the LHD on a revised Clinical Services plan which we will measure against community expectations.

- There is a need to have the ability to administer intravenous Chemotherapy in all hospitals as this causes of extreme distress and upheaval for families in Inverell.

- [redacted]

- Private paying patients should be able to utilise their benefits and recoup out of pocket expenses where applied.

- When patients are returning from major illness or injury in major sites they are returned without necessary medication. In Rural and Regional towns the medications are not always available at the local Pharmacy. The large referral centres don't realise how restricted we are in what we can procure. Utilising services across the border to Toowoomba or to Coffs Harbour is often easier if family are in those places.

- Sounds positive to share medical records however patients' permission on privacy should be respected.

Question 3

NSW Government consultation with health stakeholders and communities in remote, rural and regional New South Wales in particular:

a) **Improving communication between communities and health services (including Recommendations 5, 42) and**
b) **Developing place-based health plans (Including Recommendation 43)**

- The Government have been actively trying to find out this information and have met with these Not for profit and charities in Inverell. We are attending meetings with Allied health and not for profit local Agencies now and it's an area where Local Government is on the ground and can work to assist in an advocacy role to the State Government through the Country Mayors or even the local member. We are attending meetings to actively be of assistance.

- Regarding Local Health Committees we are in contact with the new representative from the LHD who is working to provide the Terms of Reference and how this will work in the community. In early 2025 its expected there will be Terms of reference and methods of communication established for us to collaborate. This is looking positive for now.

- In relation to Place based representation our **Inverell Health Forum** has representatives from the following:

    - 3 Medical Centres
    - Armajun Medical centre which is our First Nations centre
    - Ambulance
    - Retired Senator John (Whacka) Williams
    - 2 citizens
    - Mayor,
    - Deputy Mayor
    - Convenor is also a councillor,
    - Retired medical Trainer supervisor,
    - PHN,
    - UNE,
    - Industry,
    - Shire GM,
    - Danthonia Community
    - Allied Health Agency who wishes to attend,
    - Radiology will be invited in the New Year and wish to attend.
    - Attract connect Stay,
    - We have presentations from the ACCRM RACGP Colleges,
    - Clinical trials and many other to ascertain our knowledge and our solutions.
    - LHD is invited the Community Committee will attend

- Cross Border activity is already occurring
    - Tenterfield/Glen Innes utilise Stanthorpe,
    - Ashford uses Texas,
    - Moree uses Goondiwindi,
    - Yetman uses Goondiwindi and
    - Inverell is 3 hours from any major hospital and has no supervising Dr at the Hospital. Because we need to mostly be shipped out to Armidale or beyond many don't want to go to Hospital because they know it means leaving family, children etc. We would also like the choice to go to Coffs Harbour (out of our LHD) even across the border if family can be there.

Question 4

NSW Government action to prioritise the health of regional communities in government decision making (including Recommendation 36,37 and 44)

- Yes please.. a Regional Minister was a big help as it's a large state with a high volume of Regional hospitals of all sizes. Some LHDs with huge square km area and pockets of large and small population towns and cities. The Regional Minister provides an avenue for communication and improvement where Communities feel isolated and unsupported.

- We are unfamiliar with this final evaluation of NSW Rural Health Plan… and cannot find any record of it.

- Local communities know what is needed and where there is gaps and the Federal, State and Local government should be open to discussing this with the responsible parties and working together to have the right amount of finance supplied. We all should have timely access to health care but this is not the case. Eg if you had to travel to New Zealand to get medical help from Sydney it would not happen… you likely would get from Sydney to NZ before getting from Inverell to Newcastle. SA made Mt Gambier a training hospital and solved most issues of accessing health care and worked with the University. We firmly believe this would work for Inverell too.

Question 5

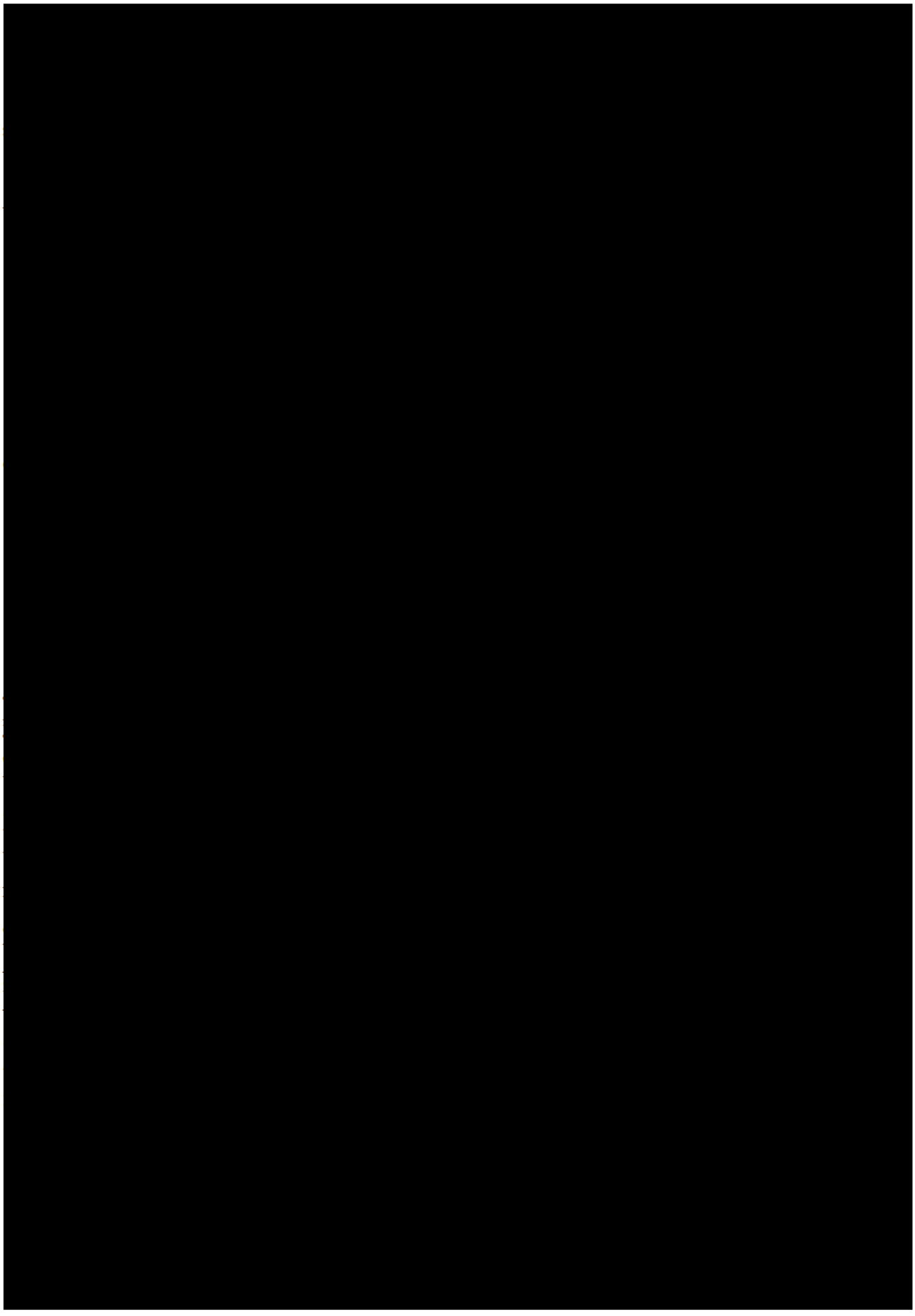
Any updates or final observations relating to the progress of implementing any Portfolio Committee No 2 recommendations that the Select Committee has considered in its previous inquiries.

- Reinvigoration and resuming of Committees are in progress over the last 12 months and we expect they may be operational in 2025.
- We are looking forward to the CEO of the LHD meeting with the Shire Council Mayor and GM and local State Member monthly from now.
- The CEO of the LHD has promised a new Clinical Services plan with stakeholders involved to enable accuracy. This is a great start
- An example of our Medical practice working with the LHD collaboratively

[redacted]

[redacted]

[redacted]



Expansion of the JMP Longitudinal Integrated Clerkship

Expansion of the JMP Longitudinal Integrated Clerkship (LIC)-Student eligibility and geographic location.

Background to the LIC: The case to train students in a rural environment.

In 2022 the JMP commenced a 19-week Longitudinal Integrated Clerkship in Inverell to provide an innovative best evidence medical education program for Phase 3 JMP students. This program complies with many of the recommendations of the independent evaluation of the Rural Health Multidisciplinary Training Program[i] (RHMT) and begins to truly fulfil the JMP SRM vision "to build a sustainable health workforce for the long-term health of our rural communities" and plant the seeds for growth of our own rural generalist workforce.

Rural Workforce Issues

Rural Australia is facing a medical workforce crisis. New England and North West NSW has only 2.3 doctors per 1000 population, compared to 4.4/1000 in major cities. The JMP School of Rural Medicine was established to help address rural workforce need however the increased numbers of graduating medical students has not translated into rural workforce. The National Data Report 2022 from Final Year Students at Australian Medical Schools (MSOD) states:[ii]

Medical Schools Outcomes Database (MSOD) 2021:

- 25.2% Australian domestic students from a rural background.
- Students from rural background express higher levels of desire to practice in rural/regional locations- 45% respondents from rural backgrounds vs 12% non-rural background.
- 13.6% graduating students plan to work in a regional city/large town and only 4.5% in a smaller town.
- Only 13.6 % graduating students plan to be general practitioners and only 4.7% want to rural generalists.
- MSOD 2021 tells us that 24.2% JMP graduates are of rural origin but only 16.9% plan to work in a regional centre/large town.

Rural Training Issues

Hospital-based training does not necessarily expose students to the breadth of the generalist medical workforce that will be required to meet the health needs of rural communities now and in the future. The RHMT[iii] independent evaluation recommends investment to incrementally increase the proportion of placements provided in smaller communities. It recommends the development of extended medical placements with exposure to general practice, Aboriginal community-controlled health care organisations, primary health care and rural hospitals to enable students to develop knowledge of the clinical skills and professional capabilities required of doctors working in rural and remote generalist models of care.

A 2016 analysis of 426 graduates from the first three cohorts of the JMP 2012-2014 found: 31% were considered to have a rural background and 40% of graduates spent one year in RCS in Years 4 or 5. 60% of these RCS students were from a non-rural background. However only 9.8% graduates were principally located in regional or rural Australia (MMM3-4) as PGY3-5[iv] The authors state: "RCS placement of at least one year does appear to be linked to PGY 3–5 workplace location, independent

of rural background and bonding status. This affirms the independent effect of positive rural exposure seen by others [9,15]. It also supports the notion that multiple strategies are required to redress the rural medical workforce deficit, and that an emphasis on rural background only could miss a group of students who, when exposed to rural locations, can see a career for themselves. **This is an important finding as it would support the policy of providing rural placements to students of both rural and metropolitan origin."**[v]

LIC project

Two Year 5 JMP students of rural origin with ambition to be rural GP's spend 19 weeks in Inverell working as apprentice rural GP's. The students are selected via EOI application and interview from students allocated to RCS for Year 5. They work across primary care; Aboriginal Health and the hospital system including ED; wards and theatres. Students follow the patient's rural health journey and move from "student to apprentice." The students are supervised by GP VMOs from Inverell Medical Centre and Armajun Aboriginal Medical Centre. The students live and work within the Inverell community and become part of the health and wider community. The JMP currently have two students working in Inverell until June 2023 and two further students planned from June until November 2023.

Evaluation of the first LIC year-2022.

The LIC pilot in 2022 has been very successful. Our four original students are now all interns. Three of the four students are currently either on the rural generalist training program or in the rural preferential internship program. The fourth graduate still plans to work rurally in the future.
A formal evaluation of the first year of the LIC has been completed and further evaluation continues[vi]

Student feedback includes:

Q3 - What has gone well in the LIC?
"The overall ability to tailor the days to not only what was happening but also my interests. This allowed great experience, exposure and learning."

"Time in the hospital - have got to experience more procedural things in the ED such as fracture reduction, relocating dislocations, suturing. I have developed friendly relationships with the staff in hospital which have made it a very positive experience going in for ward rounds every day and coming into ED regularly. On the

ward rounds, the nursing staff would bring issues to me then I would pass them on to Dr. which was a very nice experience and an insight into what it will be like to be an intern with some actual responsibilities."

"Accessibility. That being the ability to control the personal timetable to target things which are needed to become better or see things which are interesting. Support from both the university but also the supervisors here in Inverell."

"I have met a lot of lovely staff members in the hospital and GPs clinics who have made me feel welcome in their workplace. I have gotten a wide variety of clinical experiences across theatre, wards, ED, the AMS and the GP clinic. I have really enjoyed being in theatre on Thursdays with the GP gen surg lists for anaesthetics because I can participate in the induction of the patient and observe the surgeries that are happening. The ED shifts have been on the whole quite a good learning experience because you can basically be one-on-one with the ED doctor, if they're the teaching type."[vii]

All four LIC students in 2022 felt they were well supported in their ambition to become rural practitioners.[viii]

Feedback from a current semester 1 2023 LIC student. Mid semester1 2023 LIC evaluation survey.

Q3 - What has gone well in the LIC?

The LIC has been an incredible experience thus far. I believe the degree of exposure to medicine, ability to upskill and perform procedures, and integration into the team as an asset is unparalleled across the JMP placements.

The GP supervisors are extremely dedicated and provide numerous opportunities for assisting in consultations and teaching. An unexpected pleasure was the calibre of some of the Locum ED doctors, who have provided exceptional teaching of not just medical content, but also on how to work within a rural medical service, perform procedures and think clinically. In addition, the visiting specialists and allied health I've found to be delighted to have students, have provided fantastic teaching, and have done their best to involve the students as much as possible.

Furthermore, the integration of obstetrics with GP due to our multitalented rural generalist supervisors had lent a delightful twist to regular placement. I've been able to be first assist at a number of elective and emergency caesarean sections, assisted at gynaecology lists, and overall it is quite fun as a student to see your supervisors around in different roles at different times in different places. For example, one of the rural doctors in town is a GP/Anaesthetist, and I've been with him in GP, in anaesthetics, and preparing for neonatal resus. Being in a smaller health service does not simply highlight the deficit of resources or manpower in a rural setting, but also shows the unique resilience and strengths that individual doctors bring to their health service. And as a student, it provides unparalleled insight into the integration of health services into a community, and a unique insight into the patient's journey as you witness continuity of care across different locations and sites.

I think that this placement has made a tremendous contribution to my continued education, helped refine my history and exam-taking skills, and accelerated the development of my clinical framework for the initial assessment of patients, their ongoing management, and how best to care for them within a health system that can be incredibly under-manned and under-resourced.

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[i] Independent Evaluation of the Rural Health Multidisciplinary Training Program Summary of Final Report to the Commonwealth Department of Health June 2020 Appendix B Predictors for Rural Medical Practice.

[ii] NATIONAL DATA REPORT 2022 2017—2021 DATA FROM FINAL YEAR STUDENTS AT AUSTRALIAN MEDICAL SCHOOLS

[iii] Independent Evaluation of the Rural Health Multidisciplinary Training Program Summary of Final Report to the Commonwealth Department of Health June 2020 Appendix B Predictors for Rural Medical Practice.

[iv] In-Place Training: Optimizing Rural Health Workforce Outcomes through Rural-Based Education in Australia Jennifer May *, Leanne Brown ID and Julie Burrows ID Department of Rural Health, University of Newcastle, Tamworth, NSW 2340, Australia; Published: 24 January 2018

[v] In-Place Training: Optimizing Rural Health Workforce Outcomes through Rural-Based Education in Australia Jennifer May *, Leanne Brown ID and Julie Burrows ID Department of Rural Health, University of Newcastle, Tamworth, NSW 2340, Australia; Published: 24 January 2018
[vi] Default Report
2022 Inverell LIC Evaluation
December 14th 2022, 1:43 pm AEDT
[vii] Default Report
2022 Inverell LIC Evaluation
December 14th 2022, 1:43 pm AEDT
[viii] Default Report
2022 Inverell LIC Evaluation
December 14th 2022, 1:43 pm AEDT

LIC Expansion for 2024

The LIC GP Academic (Maree Puxty) has done a feasibility study of expanding the LIC to further sites, with Narrabri and Glen Innes being the next two proposed sites. The rationale for these sites is that Narrabri has a procedural GP workforce with a range of clinical activities occurring in that town. Glen Innes is a part of UNE's plan to expand healthcare delivery and student placements, and so is viewed by UNE as an important town in which to support infrastructure development. We did not consider Moree due to the proposed junior doctor positions scheduled to commence in 2024.

The proposal is for 2 students each semester be placed in Narrabri in 2024 in a similar manner to the Inverell pilot. There is strong support for the proposal from the local health district in this locations and from local GPs and other clinicians.

Funding

The ultimate aim of the LIC is for it to be sustainably supported. Sources of funding need be discussed at the JMP executive and JMP governance levels, and include consideration of allocation of the CSP and rural student grant funding.

Accommodation

Philanthropic Support- Betty Fyffe Bequest

The LIC pilot in Narrabri and Inverell will continue to be funded by Betty Fyffe bequest funds in 2024. The Betty Fyffe bequest contract will require renegotiation with the School of Rural Medicine in December 2024. Betty Fyffe bequest funds will fund LIC Academic salary and student accommodation in Narrabri.

RHMT Funding

Inverell accommodation will continue to be funded by UON UDRH RHMT as per the existing agreed arrangement.

Supervisor Payments

LIC GP supervisor payments will occur through Medicare PIP. In Inverell, two of the GP supervisors are also paid through core School of Rural Medicine funds at 0.1 FTE each.

Expansion of the JMP Longitudinal Integrated Clerkship

Student Payments

HNECCPHN LIC student scholarship: The HNECCPHN have kindly agreed to fund an LIC specific student scholarship to encourage rural medical workforce. This amounts to $250 per week for 19 weeks per student. This funding grant is reviewed annually. Currently approved $57000.00 for 2024 student scholarships.

Student sequencing.

The 2024 proposal to open up this option to urban based students is an interim solution in order to be able to develop these further LIC sites. We will likely still be piloting sites for 2024 and 2025 in a step-wise approach. Any funding costs associated with expansion to Narrabri in 2024 will be borne by UNE.

Michelle Guppy
Acting Head of School

Dr Maree Puxty
Senior Lecturer in Rural Medicine
School of Rural Medicine
University of New England
[redacted]

2 June 2023

This proposal has the support of the Head of School team and Dean, School of Rural Medicine.

Andrew McIntyre

From: Andrew McIntyre
Sent: Wednesday, 31 July 2024 8:48 PM
To: Paul Craven (he/him) (Hunter New England LHD); 'Kathy Ingham (Hunter New England LHD)'
Subject: PHN Awards Night
Attachments: 2024 PHN Awards Night.jpg

Dear Dr Craven and Kathy,

The following is an outline of the LIC program and its achievements to date.

The evening of Friday, the 26 of July, Newcastle played host to the Hunter New England and Central Coast Primary Health Network (HNECC PHN) 2024 Awards Night. The awards recognise innovation and commitment to primary care across our region. In the category Primary Care Leaders Award – Clinic / Team top honours were awarded to "The Joint Medical Program (JMP) Longitudinal Integrated Clerkship (LIC) program" which has been running now for 4 years in Inverell and Narrabri. The LIC program is a 19-week apprenticeship model of experiential learning in a rural community for Year 5 final year JMP medical students and has been implemented and nurtured by Dr Maree Puxty from UNE with five rural primary care supervisors: Dr Amanda Bentel, Dr Mary Elsley, Dr Rohana Wanasinghe, Dr Andrew Gottke and Dr Cheryl McIntyre. Students doing the LIC live, work and develop relationships over an extended time in a small rural community. Learning activities are integrated within local health services including GP Practices (Inverell Medical Centre and Bridge Street Medical Centre, Narrabri), Armajun Aboriginal Medical Service, the Inverell and Narrabri District Hospitals and, for the first-time this year, Inverell Community Health. Students consult with patients together with their GP supervisor and then follow their patient's journey. Living in the communities they become more immersed in their clinical environments, experience greater patient contact, and receive more supervision than their city based teaching-hospital peers. LIC graduates feel well-prepared, clinically confident and are more "work-ready" for their future internship than graduates from traditional metro hospital block rotations. The LIC program represents a comprehensive and innovative educational approach to addressing rural health care workforce shortages, enhancing health outcomes and fostering a positive workplace. The students who have participated in the program over the last 4 years are choosing to return to the rural hospitals as registrars and potentially as Rural Generalists for a rewarding career. We look forward to the next evolution of the program as it strives to educate, empower and produce graduates who desire to work and live in rural Australia.

On hand to celebrate the LIC program's achievement was Dr Graeme Horton (UON), Alison Tattersall (HNECC PHN), Dr Cheryl McIntyre (GP Inverell) and Kathy Ingham (LHD District Medical Program Manager – Medical Directorate)

Thankyou

Andrew D. McIntyre
INVERELL MEDICAL CENTRE
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INVERELL NSW 2360
[redacted]

Obstetrics in the Bush

The Rural Doctors Network (RDN) Outreach Student Placement Program (OSPP) provides selected medical, nursing, and allied health students with the opportunity to shadow an Outreach provider in a rural or remote community.

The OSPP is funded by the Australian Government Department of Health and administered by RDN.

Placement locations differ according to clinics visited by participating Outreach providers but may include obstetrics, cardiology, nursing, and optometry among other disciplines.

The Inverell Medical Centre has hosted 20 students from July 2023 to July 2024. These students have come from as far away as Australian National University, Charles Sturt University, James Cook University, Monash University, Newcastle University, Notre Dame University, University of Western Sydney and, more locally, University of New England.

GP Obstetrician, Dr Cheryl McIntyre, along with midwives Leanne Stokan and Erma Botes, have together been introducing young medical students at varying stages in their training, to rural obstetrics in an effort to inspire the next generation to see the possibilities of a Rural Generalist life. We are grateful for the Hunter New England Local Health District joining to allow the students to also attend Inverell Hospital and possibly even see their first delivery. This will create a memory that will last a life time and can change the trajectory of a young doctor's life, helping to breathe new life into the rural workforce of tomorrow!