New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 153

Name: NSW Brain Injury Rehabilitation Program

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NSW Brain Injury Rehabilitation Program: Submission to the Special Commission of Inquiry into Healthcare Funding

SUMMARY

- The BIRP is a networked statewide specialist service that aims to provide a seamless service of brain injury rehabilitation from acute inpatient rehabilitation through to community integration support
- Budgets and operations are managed at the level of Local Health Districts (LHDs), while rehabilitation services are provided across multiple LHDs
- Central governance is absent despite the expectation that the services are equitable, sustainable and statewide
- BIRP units generate revenue through service provision to insured clients (under fee for service agreements)

Without a level of central governance of the BIRP services there is no assurance of:

- equity of resourcing, access, and service provision
- capacity to implement statewide pilots, trials and innovations
- managing recruitment and retention challenges with a statewide lens

Background

1.1 The NSW Brain Injury Rehabilitation Program (BIRP) is a statewide network of metropolitan and regional rehabilitation clinicians providing multidisciplinary specialist rehabilitation for people with brain injuries. The BIRP was established 30 years ago, primarily for children and working-age adults sustaining severe traumatic brain injury (TBI).

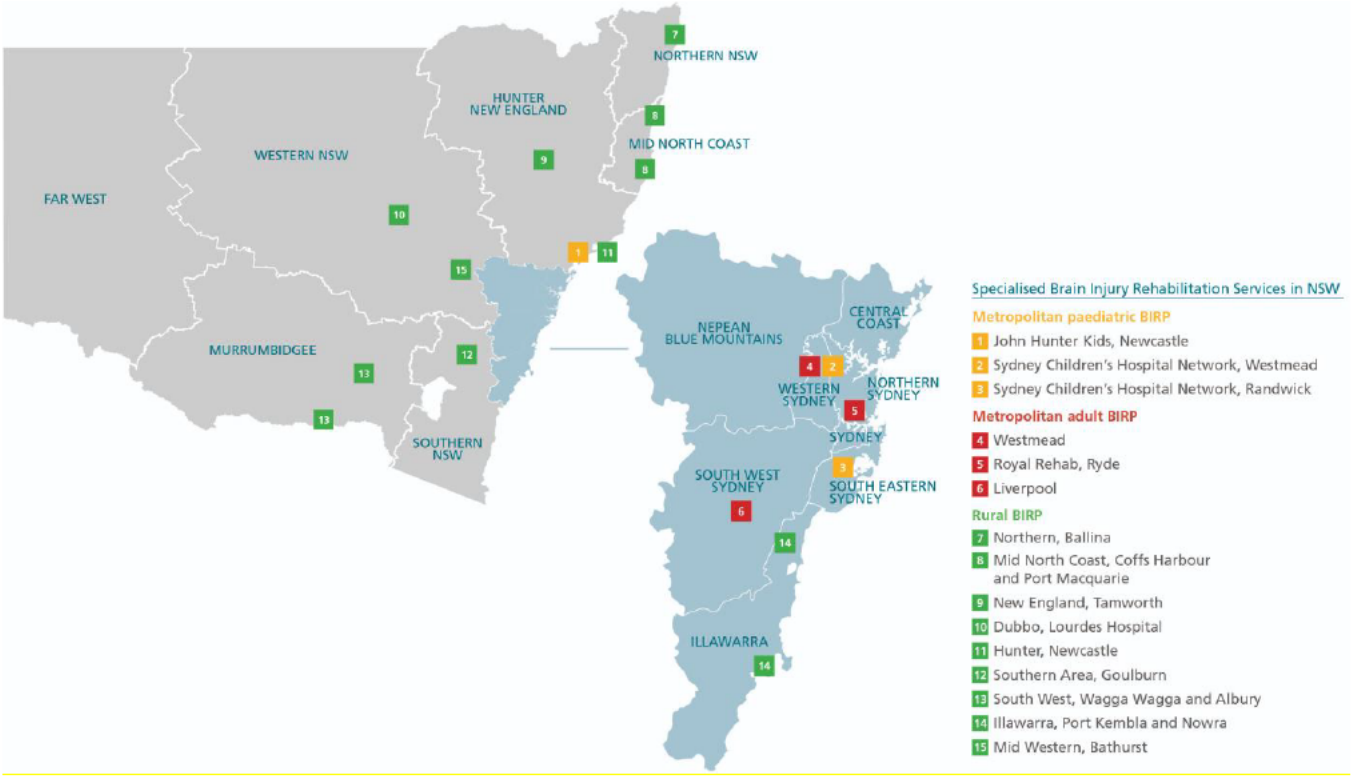
1.2 The program operates across inpatient, outpatient, community, and transitional living unit settings of care. The BIRP aims to maximise patient outcomes through the provision of high-quality, evidence-based multidisciplinary rehabilitation, with seamless transition from one setting of care to another, and services delivered in an equitable and culturally sensitive manner.

1.3 Clients of the BIRP may receive services for a period of weeks to several years.

1.4 The NSW BIRP consists of 15 different brain injury rehabilitation services spread across the state (Figure 1), with each service independently managed by the Local Health District (LHD) in which it is located (inpatient and metropolitan community children's services are managed by the Sydney Children's Hospital Network).

1.5 Inpatient specialist brain injury units for children and for adults are located in Sydney and Newcastle, with eligible patients transferring to these units from trauma services and acute wards from across NSW and interstate. Community programs are available at the Sydney and Newcastle centres, in addition to seven regional LHDs (in 10 locations). These programs continue with specialist rehabilitation at home and in the community, while also providing support to people who may have bypassed the specialist inpatient units.

Figure 1: locations of NSW BIRP



1.6 The NSW Guide to the Role Delineation of Clinical Services (Dec 2021) provides some guidance regarding the expectations of level 5 and 6 services that deliver support across the statewide network. Implementation and governance of these responsibilities is informal, and without adequate monitoring and resourcing, impossible to adequately meet.

1.7 While the network of clinicians works hard to collaborate and coordinate quality service provision and initiatives, the devolution of governance and lack of centralised oversight impacts the ability of the BIRP to:

- monitor statewide service delivery to identify gaps and opportunities for improved reach, quality, efficiency and value-add
- trial statewide innovative solutions to challenges in service delivery
- address statewide issues with recruitment and retention of staff using cross-LHD solutions.

1.8 This submission therefore focuses on Items B, C, F and G of the Inquiry's terms of reference.

B. The existing governance and accountability structure

2.1 While the *Health Services Act 1997* outlines the responsibilities of the Health Secretary in the provision of governance, oversight and control of the public health system, many of these functions are devolved to the LHDs through Service Agreements. Under the current structure, governance and accountability for the NSW BIRP is spread across 12 LHDs. There is no central oversight beyond the Service Agreement and the LHD responsibility for supporting the BIRP within their region is not itemised in the Agreement.

2.2 The State Spinal Cord Injury Service (SSCIS) and the Severe Burn Service (SBS) are nominated as "Supra LHD Services" in the Service Agreements, however there is no central governance to

support this position, nor centralised coordination of the cross-LHD function. While this submission is prepared on behalf of the NSW Brain Injury Rehabilitation Program, the key issues raised are shared by the SSCIS and SBS.

2.3 The NSW BIRP lacks central oversight, with all service-provision, staffing and financial decisions made by the LHDs. An unintended consequence of devolved decision-making is unequal access to specialist brain injury rehabilitation services across NSW. Brain injury rehabilitation is expensive to deliver, because it is performed by multidisciplinary teams over prolonged recovery periods. Patient numbers are generally small, with the incidence of severe traumatic brain injury estimated in Australia to be less than 20/100,000 people. LHDs prioritise services differently, and high-cost, low-volume specialties are particularly vulnerable to resource pressures, especially in regional and remote areas.

2.4 Equity of access to specialist rehabilitation services is critical for people with brain injuries, as impairments are frequently catastrophic and disability life-long. Adequate rehabilitation in the early recovery years can lead to better functional outcomes and reduced engagement with health services in the long term. Across NSW, there is currently significant variation in the expertise and duration of rehabilitation services that people receive. An important role of central oversight is to ensure that individual rehabilitation services are meeting minimum clinical standards, while also meeting the priorities of the local communities. Brain injury rehabilitation resources have not kept pace with service demands and population growth, with no increase in the past 20 years. Without a statewide overview, it is not possible to adequately ascertain service gaps, nor plan for future service growth and implement cross-LHD initiatives.

2.5 A key accomplishment of the networked Brain Injury Rehabilitation Program when it was established was its ability to identify the statewide needs of this cohort of patients, identify gaps and opportunities in service delivery and design and trial innovative, statewide solutions to maximise health outcomes. With the devolution to LHD governance, the BIRP is hindered in achieving this type of service development into the future.

2.6 The BIRP (and similar high-cost, low-volume services) would benefit in multiple ways from centralised governance. Most importantly, patients receiving rehabilitation services could be confident that they have access to high-quality therapies that are appropriate for their needs, rather than related to where they live. The network of expertise would be utilised more efficiently, with opportunities to create new cross-LHD programs, such as telehealth models of care delivery. Providing pathways for upskilling local clinicians by regular consultation with teams with greater experience could help to eliminate clinical variation across LHD boundaries. This is difficult when LHDs operate in relative isolation.

Impact of privatisation (iv)

2.7 The private brain injury rehabilitation sector (i.e. not NSW Health services) is mostly supported by funders such as the National Injury Insurance Schemes (e.g. Lifetime Care, CTP, Workers Insurance) and the National Disability Insurance Scheme (NDIS). Given the intensity and length of rehabilitation programs, services are seldom self-funded.

2.8 The increase in the number of private providers secondary to the establishment of the NDIS has impacted the ability of NSW Health to recruit and retain staff. Consequently, this affects the health outcomes for people who experience serious brain injury. NSW Health is currently unable to compete with the private sector on wages or flexible work agreements.

Governance structures to support sustainable workforce and health outcomes (v)

2.9 Centralised governance and cross-LHD programs and networks could provide staff with career pathways, opportunities to be involved in projects and trials, opportunities for cross-NSW mentoring and coaching programs, and shared use of specialists across LHDs via visiting or telehealth models.

2.10 Under the current LHD structure, BIRPs are small and most allied health are single-in-discipline rather than in teams of a discipline. The staff structure is flat, with often one management position for a team of clinicians. Cross-LHD shared staffing models would provide an opportunity for tiered staffing and increased support for staff working in the smaller, rural services.

2.11 Achieving a more sustainable expert workforce across regional NSW will facilitate equitable health outcomes for the brain-injured population of NSW.

C. Service delivery and allocation of resources

3.1 Activity Based Management ensures LHDs receive funding according to the services delivered to patients. How the programs and services are resourced is up to the LHD, and rightly influenced by local needs.

3.2 Over time this has led to divergence across the 15 BIRPs in what services and programs they deliver. Some BIRPs are no longer able to provide a comprehensive multi-disciplinary rehabilitation service delivered by specially trained and experienced clinicians.

3.3 Of particular concern, not all regional services can offer a service for children. This means children returning home after their inpatient care receive no assistance from a specialist team to facilitate their progress against developmental milestones or to help them and their family manage home life, return to school and engagement in social and leisure activities.

3.4 Several regional BIRP services do not offer a multi-disciplinary therapy program, instead providing a case management service. Under this model, clients with funding receive therapy from private clinicians who have been sourced by the case manager. Clients without a funder to support therapy therefore miss out on a comprehensive, specialist program.

3.5 Under Policy Directives PD2021_022 and PD2021_026 NSW Health bills the Lifetime Care & Support Scheme and other insurance schemes for services delivered by BIRPs to participants of those schemes. This generates income for LHDs which should be reinvested back into the BIRP service to ensure equitable access to services for funded and non-funded clients. Currently each LHD has its own way of setting targets, managing and reporting this type of revenue. A centralised governance system could help manage this partnership and mitigate any potential negative impacts on service availability for non-funded clients.

3.6 A centralised governance or monitoring structure for the specialty rehabilitation services should include:

- Minimum criteria for services offered across the spectrum of brain injury rehabilitation (acute to community)
- Minimum staffing requirements of specialist rehabilitation services
- Transparent understanding of where privately generated resources are allocated within LHDs

F. Workforce capability, distribution and sustainability

4.1 Retention of skilled rehabilitation clinicians within the NSW BIRP is challenging. The BIRP is often viewed as a pathway for clinicians to develop skills and expertise, prior to moving into the private sector. The NDIS and accident insurance schemes fund the private sector, which pays substantially higher hourly rates for allied health personnel compared with NSW Health.

4.2 The devolved governance structure has led to clinicians performing the same work being paid at different award rates.

4.3 Non-financial factors represent the major means by which staff can be retained within the BIRP. The multidisciplinary team environment is a major drawcard, with opportunities for clinicians to debrief with colleagues, receive direct supervision and teaching, and progress to mentoring roles. Opportunities for involvement in research and service improvement projects is also a drawcard, with many experienced clinicians seeking support for statewide initiatives to keep pace with evidence-based innovations and practices.

4.4 BIRP clinicians working regionally have additional challenges. There is a preponderance of part-time roles, small teams, a need for staff to supplement their income with private work, and greater isolation. Providing rehabilitation programs for severely impaired people is difficult in these circumstances, and moving into the private sector, with greater control of client load, is enticing.

4.5 It is best practice for people requiring inpatient brain injury rehabilitation to be treated in specialist brain injury facilities. This is not always possible, for reasons that include: no rehabilitation bed availability; the primary focus of the BIRP being TBI in the working age population, rather than the broader acquired brain injury diagnoses; and patient and family preference (especially relevant for those in regional centres). Consequently, many people with brain injuries undergo rehabilitation in non-specialist units. One solution to correct this is to increase the availability of specialist beds (noting that BIRP inpatient bed numbers have declined over the past 20 years). Supporting clinicians within non-specialist units is also essential and will be increasingly necessary into the future.

4.6 Cross-LHD governance of the BIRP offers potential solutions to some of these issues. With the ability to combine part-time roles across different LHDs, rehabilitation expertise could be distributed across NSW more evenly. A hub-and-spoke model of care, with expertise from the larger Sydney-based facilities being shared with non-specialist units and smaller regional teams, could operate more efficiently. Virtual care is emerging as a practical and cost-effective option for many rehabilitation services and would function with fewer barriers if services were funded across LHDs.

G. Education, training and supply of specialist clinicians

Training (iv)

5.1 Education and training for specialist brain injury rehabilitation clinicians occurs largely on-the-job. While adult education theory supports this as an effective learning model, it should be supplemented by appropriate mentoring and supervision and by some formal learning. Online modules are not an effective training tool for complex health interventions such as brain injury rehabilitation.

5.2 Regional community BIRPs are small in size, meaning there is often only one therapist from each discipline, which reduces access to on-the-job mentoring by a suitably qualified senior clinician.

Access to this type of support from across the statewide network is limited under the current devolved structure, as LHDs are unable to release staff to assist other regions.

5.3 The NSW Agency for Clinical Innovation (ACI) facilitates cross-BIRP networking and hosts an education committee. Clinicians run a number of Communities of Practice and interest groups within their disciplines. Webinars and forums are coordinated by ACI; it also manages a SharePoint of resources and learning toolkits.

5.4 Without a statewide vision and resourcing for cross-LHD mentoring and for development of specialist clinical learning tools, there will continue to exist a lack of educational opportunities in some key clinical areas. These include:

- Case management in brain injury rehabilitation
- Cognitive rehabilitation
- Working with people with challenging behaviour
- Building health literacy for patients and families dealing with brain injury
- Prolonged mild TBI (post-concussion) assessment and intervention

Addressing barriers to workforce expansion (v)

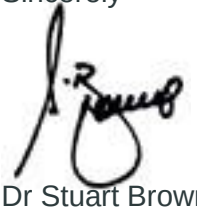
5.5 Exploring novel ways to address the current workforce challenges is difficult in the current LHD structure. Some possible solutions that require a statewide perspective and approach include:

- Sharing staff across LHDs – expanding what can be delivered via virtual care (with investment in virtual care infrastructure)
- Enabling staff to work also in the private sector (particularly in regional areas where access to private specialist services is limited)
- Enable “remote” workers – utilising a hub-and-spoke model from the regional community services
- Partner with funders – explore the potential to have a funded role (e.g. a SIRA or icare case manager/therapist) co-located and supervised by the local BIRP service.

Note: these novel ideas to current workforce issues have not been tested as the infrastructure and governance does not exist to run a trial.

Thank you for the opportunity to contribute to this important Inquiry. We welcome the opportunity to expand on this submission and be part of future consultative opportunities.

Sincerely



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