Review of Community Paediatrics
The Central Australian Remote Health Service
Alice Springs

August 2008

T. Rex Henderson MB, BS, MPH&TM, FRACGP (1974), FRACP, FRCP (Edin), FAFPHM, FACTM
Head of Department. Rural Paediatric Service
Princess Margaret Hospital for Children
Child and Adolescent Health Service
Perth, Western Australia
1. Executive summary  3
2. Introduction  7
3. Methodology  8
4. Addressing the scope of the Terms of Reference  8
5. Comments on issues raised in interviews  14
6. Governance of the Paediatric Outreach Services  17
7. In conclusion  19
8. Recommendations  19
9. Commissioning document  Appendix A  22
10. List of persons interviewed  Appendix B  24
11. Background information sources(list)  Appendix C  26
12. Performance indicators  Appendix D  27
13. Reviewers Background  Appendix E  31
Executive summary

Engagement
The Outreach Community Paediatric Services of Central Australia are at a crossroads in regard to resources, governance, and the structure of services to the hinterland.

The Author was engaged to “Review the role of Community Paediatrics in the context of a multidisciplinary Primary Health Care Team defining and distinguishing this from a hospital services role with definitive objectives and performance indicators, identifying resources available to the Community Paediatric Team and ensuring coordination with other remote health services.”

This has been interpreted as a review of the outreach community paediatric service operating out of the Central Australian Outreach Remote Health Service (CARHS) and of necessity included inquiry about the related paediatric outreach service of Alice Springs Hospital (ASH).

The outreach community paediatric service covers 35 isolated communities spread over an area of nearly a million square kilometres. The under age 16 years population in the communities varies from 50 to 500 children totalling ~5500 and suffer a morbidity level several times that of the general population and an expected longevity over 20 years less than the Australian population.

Primary Health Care
Outreach services in Central Australia are heavily dependent on a functioning and fully resourced Primary Health Care (PHC) system (Alma Ata) without which visiting specialist’s effectiveness may be severely compromised.

The current state in the Department of Health & Families (DoHF) Remote Health Centres is of a high turnover of staff and a significant net loss of medical, nursing and other health personnel. Aboriginal Community Controlled Health Services (ACCHS) currently have greater stability of staffing in their services in comparison. Both are undergoing changes associated with organizational and staff issues complicated by changing policy directions for health in the Northern Territory. Increasingly the fly in fly out model of service provision is evident in both health services. Recruitment and retention of health staff is a critical issue universally and particularly for CARHS at present with 7 out of 9 medical positions vacant.

The remarkable efforts of maintaining a health service by personnel in this environment, particularly those who have long connections with their communities is acknowledged.

Arrangement of Outreach Community Paediatric Services Central Australia
The paediatric services in Central Australia have a history of dedicated and committed practitioners who have provided leadership and expertise in engaging the multiple barriers to health care for disadvantaged isolated children.

The outreach community paediatrician’s work is predominantly outside the hospital, engaging clinical medicine, health promotion, teaching, liaison, support of other services, research, policy & planning, development of procedures, programs & advocacy for children. When resource allow operate through the principles of community development (http://wikipedia.org/wiki/Community_development) engaging within the community structures and Health Centres.

With the lack of PHC support paediatricians may be pressed to see more children in a primary capacity placing a much greater demand on and diverting this resource from its proper function.

Paediatric outreach services in Central Australia are presently provided by three administratively separate service arrangements.

Arrangement 1. A service based in CARHS consisting of one FTE paediatrician funded by CARHS, A Registrar (on maternity leave) in training funded by a commonwealth government specialist training scheme (Alice Springs Hospital is the fund holder) and a FTE Paediatric Outreach Nurse (PON) funded by the Primary Health Care Access Program (PHCAP). This team provides community paediatric
outreach to Central Australian communities through DoHF Health Centres and Aboriginal Community Controlled Health Services (ACCHS). It has gained notable popularity with its community orientated and team approach.

Arrangement 2. A service based in Alice Springs Hospital Department of Paediatrics (DOP) with two paediatricians provides a visiting outreach service to the Barkley Region and a community west of Alice Springs. This service is prone to more scheduling difficulties and more frequent cancellations due to hospital priorities. Clinics are very busy with an itinerary of one day to a full week and minimal opportunity for community engagement. The support of an outreach nurse is rarely available.

Arrangement 3. Independent services provided by two paediatricians with previous Alice Springs professional experience now living outside the NT. Services are provided to an ACCHS in Western Australia and another in South Australia where communities are orientated to Alice Springs. The arrangement is "fly in fly out" supported by the Medical Specialist Outreach Assistance Program (MSOAP). One service has two visits a year the other four, each of a week duration and supported by a Hospital Paediatric Outreach Liaison Nurse from ASH. Visits involve multiple communities spread over a wide area.

The current paediatric outreach services are inadequately resourced to visit all communities at a frequency and of a duration that is appropriate to the health status of their children as reflected in health statistics for Central Australia and the projected ill effect on future adult health.

Initiatives to improve paediatric services require an urgent addressing of a primary health care resource deficit and a need to increase staff and support resources in the paediatric outreach services and other visiting services for children including Child and Adolescent Health Services (CAMHS), Maternal Child and Youth Health Service (MCYH), Remote Allied Health, Family and Child Services (FACS). Strong supporting linkages between all these entities is crucial in developing broader skills and capacity. Greater collegiality is likely to decrease stress and increase stability and performance. Ideally all health related community services to children would have one management structure.

Hospital Relationships & Management of Outreach Paediatrics

The hospital is fortunate in being resourced with experienced, skilled senior staff with a history of long standing service to Alice Springs.

An indirect issue impacting on the provision of outreach community paediatric services however is the unsettled atmosphere permeating the Department of Paediatrics (DOP) Alice Springs Hospital (ASH) attributed to differing personal and professional styles amongst consultant paediatricians and other staff aggravated by the concern that all paediatricians may have to provide outreach services. A minority of hospital paediatricians are of the opinion that a lack of PHC services, facilities for investigation, intervention, and support aggravated by inadequate professional community paediatric training makes outreach questionable and a need to strengthen and support hospital paediatric services the priority. A counter argument is the advantages in cultural safety, family security, greater chance of attendance, better coordination and negotiation of holistic management with economic gains for family and Health outweigh the disadvantages.

Paediatricians are most productive working in their areas of comfort, strength and ability. To enforce unwilling participation would be critically damaging to the function of paediatrics in Alice Springs.

Partly as a consequence of issues within the ASH DOP the CARHS managed paediatric team is currently isolated professionally from the ASH DOP. There are considerable advantages of a closer involvement with the DOP to maintain broader paediatric skills, enhance relationships and communication that would benefit patients and practitioners. The CARHS team is on the same campus within walking distance from the DOP and able to make a significant contribution to ASH. The majority of paediatricians are supportive of this relationship.

A committee or board structure that incorporates governance of a combined paediatric outreach services through representation of stakeholders is a model that may be appropriate to develop in addressing this need and to modulate differing attitudes, philosophies and positions taken by the representative participants and organizations.
Funding and resources
Given the possibility of change, it may be prudent for the Community Paediatrics Outreach funding to be quarantined to a Primary Health Care (CARHS) or community based health organization separate from The Hospital. This would protect against erosion by hospital paediatric needs or the outreach paediatrician re-orientating to engage hospital or urban paediatrics with similar protection regarding changes of management personnel, structures and philosophies.

To provide for current and future outreach needs an increase of community paediatric resources is desirable. A further specialist paediatrician, at least another paediatric outreach nurse, administrative support of at least 1.5 FTE positions and the creation of a position of Fellow in Community Outreach Paediatrics with half time in clinical service and ½ time action research in community paediatrics in Central Australia is also desirable. The CARHS service should continue training Registrars and students as future resources.

The ASH DOP should continue to provide outreach in a similar manner to the present expanding the number of visits to the Barkley and other communities while developing a more community orientated approach as allowed by its resources including an outreach nurse. Similarly when resourced the CARHS element of outreach may appropriately support further visits to the Barkley.

Visiting health teams tax the limited resources of the remote community and are potentially disabling with their need for coordination, liaison, fetching and assisting. The availability of a Paediatric Outreach Nurse (PON) or an additional experienced Remote Area Nurse (RAN) on each visit with the engagement of Aboriginal Health Workers for language and cultural interpretation, community communication and information exchange were viewed as essential by the majority of field respondents in interviews.

The nature of assistance on visits should be negotiated to fulfil the requirements of the visiting and local service. The PON brings advantages of ongoing liaison and continuity of care while off the community and is able to liaise on behalf of families, communities and services while also supporting clinical interventions. Future possibilities in upgrading this position to Nurse Practitioner need to be considered. This may have positive and negative effects on relationships with remote centre staff depending on personalities and negotiation of roles.

An effective outreach service is more likely where a fixed schedule of visits has been negotiated and established enabling more efficient planning of transport, accommodation, rostering and communication with better coordination and relationships between, hospital wards, Hospital Paediatric Outreach Liaison Nurses, other outreach services, Health Centres, ACCHS's and visiting paediatricians in each of the various arrangements.

If resources are not available, small communities may have to loose services to maintain regular visiting to the larger on the basis of need. Regular telephone or eHealth virtual visits should then be a substitute for small communities.

Performance of the service
Performance indicators for community paediatric outreach services are difficult to establish on outcomes reliant on distant indicators such as admissions or attendances at hospital, similarly with numbers attending at community visits as the variations can be viewed both negatively and positively.

Performance indicators using process as markers are a proximal assurance of appropriate and adequate service provision by the visiting community paediatric outreach team. Compliance with a planned schedule and appropriate audit of case notes, management plans and activity in the community together with outreach support activity while in Alice Springs may offer a more appropriate reflection of performance that leads to improved individual and population health outcomes.

Supporting of performance appraisal, service planning and the efficient arrangement of forums and meetings between visiting and other services important to community children’s wellbeing will improve coordination and communication and enhance services.
Communication and Computer Systems
A program universally accessible to appropriate personnel, developed to accommodate appointment schedules in outreach clinics, hospital clinics, subspecialty clinics together with recall capacity, case notes, letters, discharge summaries and scheduled visits to communities by paediatric professionals would alleviate much confusion and tension generated over non attendance at community visits or appointments at the hospital. Significant efficiencies would accumulate the wider the accessibility.

The barriers to this initiative are significant given the number of different systems operating in the Central Australian environment however if not addressed will accelerate inefficiency, poor relationships, suboptimal care and cost.

The future
The Health Service structures in the Territory continue to evolve and are generating uncertainty and stress aggravated by the Australian Government Intervention with significantly divided opinion as to the eventual outcome. The importance of this is the possibility of expanding the community paediatric services in a negotiated and coordinated manner that may include a hybrid of service styles with a range of funding arrangements under a common umbrella to achieve better outcomes for Australia’s most vulnerable and disadvantaged indigenous children.

The apparent excess of community paediatricians required to provide the outreach services takes into account the huge travel component, preparation and follow through, the need for respite and compensation for being away, a time consuming community development approach rather than “outpatients in the bush”, the interaction with the boundaries of primary care and a greater involvement in Alice Springs town based community paediatrics with expansion of roles in teaching, research, skills development, supervision and the support of other services including the hospital.

With appropriate staffing and stability the needs of hospital and community can be better monitored through appropriate research and auditing. Natural attrition will allow further tailoring of services according to need if first a fully resourced service can be established.

With the current changes affecting the Northern Territories health services and given a collegiate and sincere unified intent there is an opportunity to establish Alice Springs as a leader in the provision of services, teaching and research in all areas of paediatrics with the attendant attraction and retention of both junior and senior personnel across the professions.
Review of Community Paediatrics CARHS

Introduction
It is acknowledged that the overall health of the indigenous population is very poor in comparison to mainstream Australia. The more remote the greater the discrepancy in morbidity, access to appropriate health care and supporting infrastructure. The cost of provision of health care is far greater and the recruitment and retention of appropriate personnel more difficult. The challenge of providing health care and resources to an often mobile widely scattered population living in small communities is daunting.

The foundations of health for the next generation of adults is now firmly accepted as being powerfully influenced by health during gestation and early childhood with the concern that without change to lifestyle and environmental factors that influence health we may see the poor statistics for health deteriorate further with a far more costly outcome socially and fiscally.

Although there have been improvements in many indicators of health service utilization over the past 2 decades there appears to be no narrowing of the “gap”.

Addressing antenatal care, the early support of infant, child and parent including community development of programs supporting early intervention and learning experiences that include the establishment of well resourced community playgroups and activities for all parents and children from birth onwards is essential. Community membership and involvement is essential in all aspects of this development and needs support with respect, encouragement and realistic expectations of an individuals interests, abilities, strengths and limitations

The Community Paediatrician has a leadership role in supporting community development, primary health care and the provision of clinical paediatric care at the community level and through program planning, development, teaching and research.

The review was conducted with this perspective in mind acknowledging the inadequate resources available in Central Australia and the disturbing rapidity of change in the social, political, workplace and bureaucratic milieu.

The Terms of Reference scoping document CARHS
Background
Community Paediatric Services are provided largely by Rural Medical Practitioners and their staff supported by two Community Paediatricians (0.5FTEs x2) working in the Central Australia Remote Health Service [CARHS].

The recent resignation of one of the paediatricians has highlighted the need for greater clarity about the role and also the appropriateness of working in relative isolation from the hospital Department of Paediatrics [DOP]. As a consequence both CARHS Management and the hospital have agreed on the desirability of relocating the Community Paediatrician to work within the DOP organisational structure whilst continuing their community service. Given this “in principle” agreement it is considered desirable that expert advice sought on the best means of ensuring:

Scope
1. The role of Community Paediatrics that operates within the context of a Multi-disciplinary Primary Health Care Team is clearly defined and distinguished from Hospital services i.e. the roles and responsibilities for inpatient, outpatient, outreach, community paediatrics and other roles are clear
2. Specific objectives and performance indicators are defined for community paediatrics.
3. The resources available for community paediatrics are clearly identified and quarantined from those required for hospital oriented work
4. Coordination with other remote health services is assured.

Methodology
A series of semi structured interviews of representative stakeholders and service providers was undertaken by phone and on a visit to Alice Springs. Themes were developed that informed and
directed recommendations on a background of information provided about the current service and the experience of the Reviewer.

See Appendix B for personnel interviewed
See Appendix C for background information resources.
See Appendix E for Reviewers background

Addressing the scope of the terms of reference

The Community Paediatric Outreach Service personnel of CARHS endeavour to provide a regular, reliable, culturally safe, competent paediatric service to patients and their families in 29 communities of Central Australia attempting to coordinate with, support, and be supported by other community resources, visiting services and professionals. The service is accommodated within a Primary Health Care provider engaging its principles and those of community development where this is possible and appropriate to promote and maintain health and wellbeing. Paediatricians of the service have engaged in policy and planning, development of procedures, teaching, supervision and research.

The Outreach Paediatric Service personnel of the Alice Springs Hospital provide a similar service to the Barkley Region including Tennant Creek and a community to the west of Alice Springs but operate from a hospital setting with a priority of meeting hospital paediatric needs.

It is appreciated that the social determinants of health require a far broader intervention than simply provision of health services given the limiting factors of poverty, unemployment, inadequate education, substance abuse, child neglect and abuse, intergenerational issues of dislocation of culture and of anomie.

The terms of reference will be addressed in order and where necessary a comment or synthesis of views will be added in clarification.

1. The role of Community Paediatrics that operates within the context of a Multi-disciplinary Primary Health Care Team is clearly defined and distinguished from Hospital services i.e. the roles and responsibilities for inpatient, outpatient, outreach, community paediatrics and other roles are clear

Community Paediatrics in this context is taken as the activity of the Community Paediatrician acknowledging the importance of the Paediatric Outreach Nurse and Remote Staff.

The role of the CARHS based community paediatrician practicing outreach in Central Australia has been described as follows:

A member of a community orientated team leading in the quest to provide holistic health care to children in communities disadvantaged by geographic isolation and other determinants of poor health prevalent in the indigenous population and environment of Central Australia.

A professional with skills in paediatric medicine, public health and community development, able to effectively engage and apply these principles and skills within the community setting.

An advocate for disadvantaged children, their families and communities for resources and services to be provided within their community.

A professional with skills to accommodate the difficulties and frustrations of working in a challenging clinical or community environment with limited resources and organisational support and able to see the importance of engaging with the resources of the community to develop relationships and enhance communication facilitating change for the future wellbeing of the community and its children.

Given the disruptions and disadvantages to personal, family and social commitments caused by frequent travel, remain able to support other workers in the communities in their professional commitment and development.
Travel by aircraft and more often by road requires a considerable time in organization and preparation for all services.

The CARHS one full time position split between two practitioners visited 29 communities with duration of 1-4 days for a total of 81 days per annum, in 2005-2006. Visit frequency to a community was 1-2 times a year. The services ideal was a visit of 3 days for 2-5 times a year in communities <300 to >1000 needing a total of almost 300 days a year for 98 clinic visits suggesting a need for three paediatricians.

The outreach paediatricians ASH contributed at least 18 with a potential of 25 days a year for visits in itineraries of 1-5 days. This includes up to 6 visits to Tennant Creek for 2 days and one day or part thereof to two Central Australian and four Barkly communities 1-3 times a year. A doubling of this service would be appropriate.

Hospital role of the community paediatrician
A paediatrician not engaged in hospital inpatient, outpatient or other hospital related work enabling maximum commitment and engagement in the community. The community paediatrician may however elect hospital involvement by negotiation to a level not impeding community work given adequate resources. Two sessions a week with compensation of the fund holder for sessions lost to community is a suggestion.

The community professional otherwise has a role in the hospital setting of liaison, teaching, advocacy, enhancing communication and relationships between community and the hospital through attendance at hospital meetings, involvement in elected outpatient sessions, case management and discharge planning of remote community children with complex problems.

By appointment the Hospital based outreach paediatrician is primarily engaged in provision of inpatient and outpatient care and has a secondary role in outreach providing a far less frequent visiting service and a lesser expectation of wider involvement in community work. A complimentary role evolving out of shared outreach responsibilities with the community paediatrician would be an advantage.

Other community roles of the Community Paediatrician
A resource and provider to other Alice Springs community based services not involved with the hospital such as the Allied Health Child Development Team and other community or visiting services in Health, Education, FAC, Mental Health Services as resources allow.

A teacher, supporter, supervisor, mentor of other staff and students.

An advocate for research in population health and of the provision of paediatric services for remote communities. An active monitor of community morbidity and children’s health status.

2. Specific objectives and performance indicators are defined for community paediatrics

Process as an objective and performance indicator
Performance indicators that measure progress toward the objective of improved child health in the communities are difficult to construct as it is apparent that given the small population numbers in each community, the mobility between communities, a significant skew in interpretation of morbidity measurements based on hospital discharges or A&E attendances may occur. This approach would not reflect the activity of the paediatrician nor necessarily would more distant outcome measures of wellbeing.

The failure or success of the paediatric service will not be obvious through proximal morbidity figures whereas the provision of services may be if monitored. For this reason, process is suggested as a better initial indicator of activity while developing other more robust measures through research & audit. The processes selected should be part of the paediatrician’s routine work with a little extra effort involved in documentation and reporting. The completion of all the possible events suggested in appendix D “Performance Indicators” is impractical. The list is a reflection of many activities
undertaken that are suggested possibilities. Selection of criteria would be negotiated the first four would have priority.

Specific Objectives
The broad objectives expressed by the current CARHS paediatric outreach team are: “(a) To provide high quality visiting paediatric services in remote communities, (b) education and training in child health issues for remote and urban practitioners, (c) paediatric input into policy and program development within the NT, (d) advocating for indigenous children at individual, community and population levels.”

In keeping with the commentary regarding performance indicators the distant objectives of improved health may be difficult to establish in regard to community paediatrics given the current resource poor PHC and paediatric services. Using processes that ensure service provision as objectives, as suggested for measurement of performance, may also be appropriate while better markers are developed. The individual objectives in this review may therefore be read as an integral part of the individual performance indicators as listed in Appendix D.

Major objectives/indicators
The commitment to regular scheduled visits should be a major objective/indicator as should the planned activities on the visits. Evidence of other performance achievements as suggested in appendix D would be made available by the paediatrician or management at the time of performance appraisal and could be in the form of an annual report.

The personal performance appraisal meetings content and frequency should be negotiated between service personnel and management. By default suggested intervals would be initially at 6 months, 1 year then 2 yearly using the performance indicators suggested and involving a Senior Hospital Paediatrician and a Senior Community Paediatrician or Senior Community Medical Practitioner with a support person of the appraisees choice. The appraisal to be formally registered with the Clinical Administration of each entity.

The performance measurements discussed are of a nature acceptable by the RACP as points for attaining good standing in the maintenance of professional standards within the College and may already be recorded by paediatricians for this purpose.

Negotiation and refinement of indicators
The suggested indicators, as listed in Appendix D are representative of community paediatric activity and should be negotiated and refined with major stakeholders. If agreement cannot be achieved default indicators consisting of compliance with the visiting schedule and visit activity content items 2a to 2d with three other listed suggestions considered. All visiting outreach paediatricians would benefit by regular performance appraisals as would hospital paediatricians.

The process performance indicators listed in Appendix D will also mark progress toward the objective of improved access for and engagement with community paediatric services by families and children in communities and should apply equally to the CARHS and ASH paediatricians in their outreach roles.

Performance Indicators
A list of performance indicators is found in Appendix D.
3. The resources available for community paediatrics are clearly identified and quarantined from those required for hospital oriented work.

Quarantining of operational funds
A general concern expressed in bringing the CARHS outreach community paediatrician into the Department of Paediatrics Alice Springs Hospital is the possibility of funding being eroded to support valid hospital paediatric needs at the expense of the remote communities visiting services.

Evidence suggesting this is of the Hospital Paediatric Outreach Liaison Nursing positions historically linked to CARHS drawn into a more hospital orientated role and a hospital paediatrician needing to cancel visits because of clinical emergencies and hospital priorities. Historical evidence from other jurisdictions also supports this concern. Similarly a community appointed paediatrician may orientate to hospital paediatrics and excessively bias their work and commitment away from outreach and community.

Several management possibilities have been proposed to address this issue based on where funds are held for example protected by CARHS or a third party that is population or community health based.

The two current styles of outreach service provision by CARHS and The Hospital may remain unaltered or be managed similarly regardless of fund holder. Service agreements, MOUs, cross over joint appointments, purchasing of services are all possibilities with equal strengths and weaknesses. Joint appointments may give greater security and easier formal management but risks impacting on commitment to visiting schedules and may cause difficulties if resignation occurs from only one institution.

CARHS resources that need to be conserved
The current Paediatrician FTE, Paediatric Outreach Nurse (PON) FTE, shared administrative position, all flight and road transport expenses, overtime, travel allowances and expenses, office accommodation, computers, telephones, recorders etc and logistic support for the team including Registrar all beg quarantining.

It would be preferable for the Paediatric team to remain in proximity to the PHC providers while there remains a CARHS visiting PHC service. The outreach paediatric team’s base should have proximity to other community oriented health services to maintain a community focus while still providing significant community oriented input to the hospital. Residing within the hospital offers greater engagement in ward and OPD clinical work with advantages of liaison and collegiality but risks significantly isolation from the community service base most important for continuing influence and legitimacy.

Preferred establishment
A preferred establishment of the CARHS outreach community paediatric team to meet expected commitments would be

<table>
<thead>
<tr>
<th>Clinical Position</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatricians</td>
<td>2.0</td>
</tr>
<tr>
<td>Senior Registrar</td>
<td>1.0</td>
</tr>
<tr>
<td>Fellow</td>
<td>1.0 (0.5 research)</td>
</tr>
<tr>
<td>Child Health Nurse Practitioner</td>
<td>2.0-3.0</td>
</tr>
</tbody>
</table>

Administrative
Clerical with typing and reception 1.5-2.0

Accommodation
Office space with minimum 5 rooms and a records area
In RHS to allow liaison on a daily basis with Primary Health Care Team
Teleconferencing facility (Telmed)
Meeting room, Equipment room
Telephones, digital recorders, computers, typing services.
Travel Costs and accommodation
CARHS charters aircraft for its DMOs and Paediatric Team often with vacant seats available. A similarly experience occurs for the Medical Specialist Outreach Assistance Program (MSOAP) flights for its various specialists. A coordinated approach between agencies has been attempted for flights and visits in the past with difficulty experienced around lack of visiting schedules, poor communication and cooperation between parties. There is an argument for leasing or arranging regular charter and “selling” seats to other agencies to attain economy and assist control of random visiting of communities.

A common on-line travel calendar is currently used by only a small number of service visitors to communities. Wide use of this facility would potentially improve efficiency and cost of community visits.

Paediatric visits may be more efficient if flying was accessed more frequently than driving particularly if recruitment of further paediatricians fails.

The inadequacy of isolated community accommodation is a significant issue for visiting teams and requires urgent attention

All projected travel cost should be quarantined for community paediatrics visits including the need for vehicles.

Professional inducements
(Vacant positions to be advertised nationally)
The Community Paediatric Positions should be classified as Specialist Paediatrician with the same remuneration steps and identical conditions of service to the Hospital Specialist Paediatricians

An encouragement to remain long term in outreach community paediatrics in Central Australia will depend on the attractiveness of salary and conditions of service and appropriate compensation for travel, disruption of lifestyle and would include

Time in lieu for disruption of lifestyle, inconvenience and overtime or alternatively paid the equivalent.
An additional half day for each day on community is an appropriate estimate.
Generous study leave to develop and maintain formal skills in Community Paediatrics including behavioural and paediatric psychiatry.
Time for supervision of Registrar and Fellow.
Teaching time: for community, hospital and other professionals
Administration time
Research time
Sensible allocation of travel days and times.
Work in communities to be equivalent to one full working week in three. The estimated administrative, non contact clinical and liaison time involved for the completion of a visit is estimated to be one day for each complete day of community consulting.

Several funding opportunities have been suggested to support the expansion of the visiting team and have included. AGI phase 3 funding through the primary care initiatives. The Hospital has however not attracted an applicant for a temporary position in ASH funded by the AGI. This needs to be addressed and made attractive as suggested above.
DOP should fund the ASH component of community paediatrician’s clinical work in Hospital.
Universities (Centre for Remote Health) be approached in regard to the Fellow position and the research component seeking support, supervision and assistance in grant applications (Grants from State, Commonwealth etc)
The funding of the clinical element of the Fellow’s position would be split from DoHF or Commonwealth by both CARHS and Hospital.
Financial support for clinical services should be explored through MSOAP by suggesting the new paediatric position is a new initiative.
Investigation of Medicare as a supplement to DoHF funding. Paediatricians need to be protected from legal risks if this is considered.
Cooperative ventures with ACCHS’s, who may be interested in purchasing further paediatric services from CARHS or the funding body.
4. Coordination with other remote health services is assured.

Relationships
The management structure of the DoHF remote visiting services does not naturally enhance coordination and liaison with the community paediatric services or each other. Unless engaged through formal meetings or chance collision on communities there may be little information shared with the community paediatric team. Allied Health Remote and Child health Nurses communicate with the CARHS paediatrician about children of concern. The potential for efficiencies in service through enhanced discourse between MCYH, CAMHS, FACS the PHC (including ACCHS’s) teams and the outreach paediatric team is apparent. Resources and intent are the limiting factors.

Accommodation limitations on communities create a difficulty where extended teams or combinations of visitors would otherwise be beneficial.

Communication difficulties are evident in both DoHF, independent and hybrid health centre systems. Structure, lack of resources and interpersonal issues are factors underscored by the changes occurring in the Territory’s Health Services reorganisation and the Australian Government Intervention.

The primary health care doctor’s collegiate network is reported to be functioning poorly. There are difficulties experienced in the ACCHS’s network. The critical shortage of DoHF District Medical Officers (DMOs), the fly in fly out arrangement for many ACCHS’s PHC doctors and for two CARHS DMOs on a background of high turnover of all staff makes continuity for developing collegiality in this group difficult.

For this reason a more formal negotiated structure to enhance communication and coordination of services is paramount for all visiting services including paediatric services.

Performance indicators
Performance indicators for the CARHS Outreach Community Paediatrician as described underscore the importance of relationships and communication between professionals and organizations that provide resources to remote communities and will reinforce this commitment. Monitoring may suggest appropriate action where communication deficiencies become apparent

Meetings and forums
Meetings as described in the performance indicators appendix D should be formally structured with agenda, action and reporting responsibilities. Resolution of conflicts or issues in service provision may be possible through this medium.

An annual update forum with a review of performance of visiting services to communities and involving all service providers or there representative would be an exercise encouraging communication and coordination between services.

Accreditation of Services with appropriate national quality and safety organisations should be the intent of all Programs and Services.
Comment on themes raised from interviews

Relationships and communications
Throughout the process of the review it was apparent that where relationships and communication were open and honest a better service could be established dealing with obstructions and deficits in a supportive and constructive manner. There are difficulties (as well as advantages) of living in small communities with the stress of cultural dissonance, working and socializing with a small group of people where choice is limited. In larger institutions and towns a different form of isolation may be experienced.

Paediatric visits, patient attendance and PHC resources in communities
The poor retention and high turn over of Primary Health Care staff with varying experience in remote health, contemporary indigenous culture and paediatrics increases the potential of a poor patient attendance resulting in a disappointing and inefficient specialist visit.

The extra workload generated by a visit may be disabling to other PHC programs and immediate care particularly as finding and containing children is commonly time consuming and difficult with a likely poor attendance. Extra assistance at this time is crucial to a successful visit. A demonstrated successful role for the Paediatric Outreach Nurse.

The infrequency or absence of DMO visits to most DoHF serviced communities loads the health service with a pressing adult chronic disease burden and children with hidden chronic disease are unlikely to be known or receive attention complicated by family perceptions in regard to health, health services and their use. The attendance of the paediatrician requesting to see the child may be the only alert to the child's chronic disorder and the need for monitoring and intervention.

The dynamics and relationships in communities are complex. An active, compassionate and aggressive support for field staff is needed from management and visitors.

Allied Health multiskilling and paediatric services
Allied Health resources are also under stress with professionals multiskilling across the allied health spectrum attempting to meet community needs. They demonstrate a remarkable tenacity and ability to liaise and communicate between themselves and the Health Centre staff enabling a much broader array of skills and benefits to be available to the remote community. Paediatrics is often the weakness in this committed resource for all community members regardless of age. The elderly infirm are the major consumers through need for assessment and service.

Maternal Child Youth Health Nurses activity on communities
The lack of a clinical management role for the visiting Child Health Nurses (CHN) was raised against her major role of health promotion and support. The support in development of childhood services such as playgroups and other child and parenting activities was seen as essential. A role similar to the chronic disease nurse but for children was floated.

Communication with the Community Paediatrician through correspondence, email and if by accident on community together appears effective. Some communities saw an advantage of having a CHN full time.

The place of youth workers, many of whom had inadequate orientation and background in dealing with culture and isolation was questioned particularly as many needed significant support themselves. Better selection, orientation, supervision and support systems are needed to have youth workers be effective.

Chronic Diseases Nurse
The chronic disease nurses in both the department and independent systems are overburdened by the need of adults with chronic disease and have little involvement with children. By default the RAN and paediatrician are engaged in this role.
Schedule comparisons with Darwin outreach paediatric visiting services.
The Central Australian service differs from the Top end in that communities are smaller in Central Australia with less PHC medical support and less use of air transport. The Darwin based visiting service has a larger number of hospital and private paediatricians (10 + Registrar) who provide outreach and hospital on call in addition to their substantive clinical roles. There is not a dedicated FTE position to outreach. There appears to be a supportive collegiate atmosphere for this outreach initiative with forward planning, coordination and scheduling of visits.

The Top End paediatricians visit their communities more frequently and all by air with visits to communities of mostly one day duration with some community itineraries up to 4 days for a total of 215 days per year in 2007. Visit frequency to a community varies between 3-11 times a year depending on size and need.

This compares with CARHS 1 FTE Paediatrician visiting 29 communities with tours of 1-4 days totalling 81 days and with mostly 1-2 visits a year in 2005-06.

This is not inclusive of ASH outreach paediatricians visits to the Barkley with 4-6 visits a year of 3-5 days duration to 5 additional communities including 2 days at Tennant Creek and three one day visits to a community cluster west of Alice Springs totalling up to 25 days a year. Conflict with hospital responsibilities creates issues resulting in short term planning, cancellations, deficiencies in coordination and communication aggravated by administrative and clerical deficiencies.

Length of stay on communities
Currently communities will receive two visits a year maximum excepting Tennant Creek with up to 6 visits per annum. The desire of most centres was for a more frequent service than they currently received. Most felt 3-4 visits a year a reasonable compromise. Tennant Creek would benefit from a preferred monthly frequency with a longer stay than the current two days of 1 day Hospital and 1 day Aninginyini Health Service. There are issues of communication and organisation between the visiting service and the latter clinic that require resolving.

If a paediatrician stays in a community for longer than one day more children with significant issues attend as those with the most complex issues tend to come from families least likely to access health care. A sound grasp of how systems function in the community and a deeper understanding of reasons for non attendance and non compliance is gained particularly if working with committed Aboriginal Health Workers. This leads to greater satisfaction, better relationships, greater efficiency and healthier outcomes. The paediatrician also becomes more available as a support and resource to community staff.

The legitimacy and influence of the paediatrician appears enhanced when able to visit schools and other community institutions where children attend and opportunities for assessment and health promotion avail.

Administrative support
The lack of dedicated administrative assistance to help manage visits, communication, correspondence, typing, records and secretarial duties is a significant contribution to the often commented disorganisation, stress and inefficiency that results for communities and visiting staff. The management of outreach as a unified team with appropriate supports would address this.

Fly in Fly out Services.
The increasing use of interstate professionals for fly in fly out service provision is evident in all professional fields. Continuity, coordination and liaison become critical issues where strained Regional resources may have to manage on limited information and support between specialist visits. Correspondence is often problematic after the visits and continuity of care may be compromised. Some communities have benefited from strong relationships that have developed with a specialist or other professional consistently providing services to the same communities while supporting colleagues and other local resources over a long period despite being FIFO. Psychiatry is notable for this.

This form of service for paediatrics should be considered only in default of inadequate local resources.
Misunderstanding of the outreach community paediatrician’s role
The practice of the outreach community paediatrician has had several viewpoints expressed in Alice Springs. One view is of a peripatetic paediatrician limited to hospital style outpatients in the bush. A counter view is of a paediatrician providing ambulatory care to children with complex paediatric problems while supporting Primary Health Care (Alma Ata) principles and public health processes promoting and enabling wellbeing. This includes involvement in policy development and advocacy for children’s wellbeing while working cooperatively with family, school, community, other agencies and professionals. The later model embraced by the CARHS team.

Future directions of community paediatric services.
The morbidity of childhood in Central Australia will continue to change with less acute and shorter admissions to hospital and a greater focus on other life style disorders in child hood such as obesity, diabetes mellitus, behavioural and learning difficulties, family dysfunction, psychiatric disorders, the consequences of social stress, substance abuse and residue from complications of pregnancy such as Fetal Alcohol Spectrum Disorder and prematurity. This by default will impact the community paediatrician as visiting resources from Psychiatry, Psychology, Education, Allied Health and Social Work are very unlikely to be sufficient.

Given this unmet need community paediatricians should be supported in skill development in the psycho-social / psychiatry domain with attendance at appropriate conferences and seminars with mentoring from local expertise, visiting psychiatrists and psychologists. A supportive collaboration with MYCH and CAMHS is vital.

A senior paediatrician with broadly developed skills has played a role in this area within Alice Springs.

Adolescence is another area of poorly met need in hospital and community due to lack of resources and expertise. A similar developmental initiative is appropriate to support current efforts for addressing this group.

There is a need for a more formal Child Development Team structure and to include a community paediatrician, additional allied health professionals including social worker and psychologist. The greater the collegiate support for scarce professionals the more likely their recruitment and retention.

Advocacy for early intervention in developmental disorders, early childhood education and developmental experiences in preparation for school and the support for a psychiatry initiative of early intervention in infancy for attachment disorders could engage significantly the community paediatrician’s time.

The current combined staffing of paediatricians in ASH and CARHS appears inadequate to meet current and expected demand particularly as community ambulatory care is likely to be a far more dominant activity in health in the future.

Communication difficulties and delays between ASH and community...
Difficulty was frequently expressed in accessing patient information from the paediatric ward if a familiar person could not be contacted. Ownership of assisting valid inquiries would assist the building of good will in this arena.

As with many large hospitals the issue of discharge summaries arriving very late, not at all or being poorly informative arose repeatedly. Similarly with the paucity of subspecialist letters reaching communities and the manner in which appointments are notified.

Notifying families of appointments is complex. Knowledge is required of local community systems of communication and handling of correspondence. Literacy, an understanding of the importance of an appointment, mobility, poor transport facilities, the dispersed nature of some communities, family safety and other priorities all conspire to interfere with a successful attendance and a cause of frustration. The need for careful eliciting of patient mobility and liaison with community should be communicated to all new staff.
Review of Community Paediatrics CARHS

The community paediatricians when resourced should be well placed to assist minimising revisiting to ASH. The value of the Hospital Liaison Paediatric Nurses in their outreach role was uniformly acknowledged in addressing these issues as was the concern that they were under resourced to meet expectations. The multiplicity of their roles and heavy engagement within the paediatric ward and outpatients, a significant dependence on personally held information suggests a need to define the roles of this position and reallocate duties appropriately. This is particularly urgent given the expected departure of a long standing iconic member of the staff.

Stress in the DOP ASH
The unsettled professional atmosphere in the DOP and Children’s Ward was evident from comments made within and outside the hospital by professionals of different backgrounds. Differences in personality, philosophy, practice styles and leadership expectations are some factors involved with a division that obstructs collegiality and progress of the DOP and outreach paediatrics. The concern that all paediatricians may have to perform outreach has aggravated this atmosphere. There was no criticism raised about the commitment or inpatient service provided by the hospital clinical staff apart from questions of communication, early discharging without considering the inadequacy of safe accommodation for community families in Alice Springs.

There is an awareness of the great possibilities for paediatrics in Alice Springs if these issues can be acknowledged addressed and leadership embraced by all senior staff.

The hospital has an external review of the DOP involving this issue.

Governance of the community paediatric outreach service
Models of management of the outreach community paediatric service

Prior to this review discussion had occurred locally as to possible models for provision of paediatric outreach services in Central Australia. Suggested models included

1. All paediatricians to provide outreach and perform hospital work. This would be unworkable given the position of some paediatricians in regard to performing outreach. Enforced engagement would be of further detriment to the department and have a negative influence on service provision to the hospital and communities involved. Similarly a community paediatrician may not be skilled or desire to engage in inpatient hospital work. A strong commitment is needed for effective outreach and similarly a balanced strong commitment for a robust hospital service. Both should be accommodated and supported. This model is not a preferred option currently.

2. A fly in fly out arrangement of Paediatricians living in or outside Alice Springs Contracted to provide regular services for a week or longer, at specified intervals to the same communities as is the model for the two independent ACCH’s.

The concern expressed about fly in fly out is the possibility of poor continuity between community and hospital particularly where children are sent into ASH for investigations or management. Differences in management perspectives may raise a conflict in care. Similarly if the paediatrician providing the visiting service is unfamiliar with local services and management style in Central Australia there would be a potential for poor communication, conflict and mismanagement. It is not a preferred option.

3. A community orientated paediatric team providing the bulk of outreach and Community Paediatrics supported by a team of hospital based paediatricians who are keenly interested in outreach.

Funding for outreach would either stay with CARHS or a similar community orientated body or passed to the hospital to manage.

A concern with ASH as fund holder is the loss of community time if hospital priorities gain precedence or the paediatrician elects to sacrifice excessively, community time for hospital work. Funding arrangements may need to involve service agreements, a memorandum of understanding or the Hospital or CARHS purchasing services from the other or by cross appointments made on a sessional basis.
A management advisory committee or Board structure of a strictly limited number of 4-5 stakeholders, Hospital, CARHS, ACCH’s and Community representation may help resolve areas of conflict of interest and modulate the perceived difficulties in management and leadership experienced at both ASH DOP and CARHS.

One intention would be to integrate the hospital visiting outreach team and CARHS outreach services and in time the other paediatric services as appropriate. The team would include the Paediatric Outreach Nurses, Hospital Outreach Liaison Nurses, Paediatricians and supporting administrative staff. Ideally all paediatrically related outreach services would eventually be under the same umbrella enhancing communications and effectiveness.

A Paediatrician should be elected to oversee day to day management of operations. The concept of a rotating Head of Department may be considered for Community Paediatrics and indeed the DOP.

By default with funding remaining with CARHS, day to day management may be through the Director DOP and reviewed annually. Similarly if all paediatric services including hospital were to be amalgamated it has been suggested two representatives could be appointed one to manage the hospital and the other community outreach.

In all models current paediatricians electing not to do outreach are accommodated.

Community Paediatricians may choose to engage inpatient hospital work and be on call providing it is limited and without impediment to their outreach or community paediatric commitments. This arrangement would have to support outreach as a priority. A well planned visiting schedule would be mandatory.

The partitioning of outreach service areas should follow language groupings where possible with the same provider visiting the same communities with a “backup” known to the communities by occasional visits. Community mobility is likely to be within language areas and consistency of provider would enhance development of community relationships, encourage cultural sensitivity and appropriate behaviour.

As the ASH has traditionally supported the Barkley and Tennant Creek it is appropriate this continue.

Opinion from remote centres suggests visits to larger communities should approximate 4 or more times a year with Tennant Creek more often. For other communities a visit three times a year with the smallest on merit of need. Visits would be for 1-4 days. Visits would be arranged by negotiation with communities.

This formula presumes a full CARHS staff commitment of the proposed two specialists, registrar, two to three outreach nurses and the current or greater hospital commitment with the desirable addition of a Fellow contributing 0.5 FTE. The Fellow should embark on a study of outreach service provision to develop a stronger evidence base for future decisions on appropriate visiting of communities and staffing structure.

It is sensible to have the full time community paediatrician limit where possible visiting on community to no more than 0.4 of there working time averaged per year unless the visits are all completed in one working day.

Non contact work required before and after an outreach visit is estimated to be equivalent to a day for each day on community. Compensation for the inconvenience of performing outreach and overtime while on outreach equates to ½ a day for each day which may be taken as TOIL as in other jurisdictions.

In default of sufficient resources the visiting of each community would be progressively reduced by a visit per year further reducing to the current plan for twice a year with smaller communities no longer receiving a service. It may be better to sacrifice services to small communities maintaining a scheduled phone contact and concentrate more frequent visits on large communities. The outreach community paediatrician should not be expected to exceed 6 days on community out of three working weeks.
In conclusion
This review has reflected the importance of relationships, communication and leadership in exploring and developing approaches to achieve meaningful health outcomes for disadvantaged Central Australian children through services that are more accessible and acceptable to families and communities.
Substantial resources will be required

Recommendations

Resources
1. The NT Government maximize every opportunity to address the underlying determinants of ill health and inadequate access to Primary Health Care in the indigenous community in The Northern Territory and address urgently the issue of recruitment and retention of Primary Health Care and other Health Professionals in remote areas.

2. CARHS increase staffing by one FTE specialist paediatrician who preferably has the qualifications or experience of a community paediatrician. All paediatricians should be recognised as and be employed on similar conditions of service as Hospital Specialists. Clarification with DOP the employment intentions of the temporary Australian Government Intervention funded Paediatrician position. The funding of this position together with the Registrar Outreach should be held by CARHS.

3. CARHS appoints a further 2 Paediatric Outreach Nurses and considers an 0.5 Social Work position.

4. CARHS and ASH consider appointing and funding a Fellow in Community Outreach Paediatrics 0.5 clinical and 0.5 research with the latter supported by grants and fellowships. Alternatively utilise the Registrar position in a similar manner to develop an information base for future planning decisions.

5. CARHS appoints 1.5-2 administrative assistants/clerical staff to support the CARHS Paediatric Team and Hospital Visiting Paediatricians.

6. A Paediatric Outreach Nurse to accompany paediatricians on a majority of visits to assist with clinic management in negotiation with the primary health care providers.

7. Employment of appropriately experienced nurse volunteers from the ASH Paediatric Ward as regular support for paediatric visits to communities while awaiting establishment of further outreach nurse positions.

Governance
8. Funding of the outreach paediatric service should be held by a Primary Health Care (PHC) or other community orientated health body e.g. CARHS

9. All travel costs of aircraft charter, vehicles, accommodation, allowances and inducements for the paediatric outreach team both hospital and CARHS be quarantined to a PHC or other community health orientated body e.g. CARHS

10. The CARHS Outreach Paediatric Team be located in an environment supporting and being supported by community based health professionals e.g. CARHS

11. Management of the Outreach Paediatric Service (combined) should be through a structure, advisory committee or board consisting of representatives of the Hospital, CARHS, ACCHS and the Community regardless of fund holder. Operational management should be by an elected outreach service paediatrician from hospital or CARHS.
12. Develop contingency measures in the event of insufficiency of outreach staff. Services should be curtailed to support larger communities with regular visits. Paediatricians should spend no more than an average 0.4 of their effective working week visiting. This is exclusive of all leave.

Performance
13. Paediatric community visits to be planned, scheduled and fixed a year ahead with contingency plans to prevent cancellation.
14. An initial plan to be the currently scheduled frequency of visits with additional visits added to the schedule as the service is resourced.
15. Frequency and duration of paediatric visits to be negotiated with ACCHS and DOHF Health Centres taking account of resources available to the combined CARHS and Hospital visiting paediatric outreach team.
16. Service performance to be assessed initially on (a) compliance with the planned visiting schedule (b) compliance with planned professional activity for the year.
17. Attendance of the CARHS Community Paediatrician at hospital clinical and professional meetings to present a community perspective and advocacy for children in the community and to build collegiality.
18. Performance appraisal to be part of a regular assessment for all practitioners.

Hospital attachments
19. CARHS outreach community paediatricians to have access to outpatient sessions at ASH and have elective admission rights for children from communities for investigation and management.
20. By choice the outreach community paediatrician may elect to engage in limited inpatient hospital work.

Senior Paediatricians and outreach
21. Current Senior Hospital Paediatricians with an acknowledged strong reluctance to perform outreach should not be expected to do so. All future appointments however should have support of outreach service included as part of the duty statement.

Liaison, communication and development
22. Negotiate with other community paediatric related visiting services and resources a regular and efficient forum for service coordination and liaison. E.g. Remote Allied Health, MCYH, Visiting Midwives, CAMHS, FACS, Student Services, and other NGOs.
23. Outreach Paediatricians to continue attending interagency and case management meetings and providing summarised information for their service, colleagues or patient’s notes.
24. Maintain a strong presence of Central Australian community and hospital paediatric opinion and experience at policy development and planning levels within DoH.
25. Clarify the outreach duties of the Hospital Outreach Liaison Nurses as distinct from ASH OPD and ward duties and support quarantining this important role, placing it within a unified outreach team.
26. Engage the Hospital Outreach Liaison Nurses in assisting development of a computer program/system integrating discharge summaries, appointments for
outreach, OPD and monitoring of follow up that interacts with The Territories developing IT network and multiple ACCHS systems.

27. A community paediatrician be appointed to the Child Development Team Flynn Drive Alice Springs, when resources available.

28. A community paediatrician engages with CAMHS to up skill in paediatric psychiatry/psychology and provide in return a paediatric input. When resources are available.

29. Long term planning to develop a well resourced community and outreach paediatric service for town and remote areas with all professionals managed under a single umbrella.

30. Detailed planning starting immediately to provide a template for an ideal outreach and community paediatric service for Central Australia guiding and enabling the DoHF in fund allocation. The plan will include and should be developed with other related services. A plan readily available and costed is more likely to be attractive to an administration when allocating funding.
Appendix A

Commissioning document for the Review of Community Paediatrics in The Central Australian Remote Health Service Alice Springs

Background

Community Paediatric Services are provided largely by Rural Medical Practitioners and their staff supported by two Community Paediatricians (0.5FTEs x2) working in the Central Australia Remote Health Service [CARHS].

The recent resignation of one of the paediatricians has highlighted the need for greater clarity about the role and also the appropriateness of working in relative isolation from the hospital Department of Paediatrics [DOP]. As a consequence both CARHS Management and the hospital have agreed on the desirability of relocating the Community Paediatrician to work within the DOP organisational structure whilst continuing their community service. Given this "in principle" agreement it is considered desirable that expert advice sought on the best means of ensuring:

Scope

5. The role of Community Paediatrics that operates within the context of a Multi-disciplinary Primary Health Care Team is clearly defined and distinguished from Hospital services i.e. the roles and responsibilities for inpatient, outpatient, outreach, community paediatrics and other roles are clear
6. Specific objectives and performance indicators are defined for community paediatrics.
7. The resources available for community paediatrics are clearly identified and quarantined from those required for hospital oriented work
8. Coordination with other remote health services is assured.

_outreach community paediatric services_

Companion to the commissioning document

Historical background

10+ years ago the then SDMO had an interest in children and concentrated on paediatric services to the remote communities of Central Australia. From this evolved a specific SDMO/SRMP position within the Central Australia Remote Health organisational chart for an Outreach Community Paediatrician.

1 FTE Community Paediatrician delivered the service; due to the workload the incumbent reduced his hours to 0.5FTE and an Alice Springs Hospital Paediatrician covered the remainder of the position. At this time the hospital invoiced CARH for the services.

With the Pending resignation of the Community Paediatrician in mid '07 the ASH specialist became a full-time employee of CARH; so for a period 9 months CARH had 1.5 FTEs. This now has been reduced back to 1 FTE as of April '08; held by one Paediatrician.

Recently a Paediatric Registrar commenced. Both CARH and ASH Paediatric Division had supported the establishment of a training registrar position via the Expanded Settings for Specialist Training Programme. The fund-holder for this position is ASH.

It is recognised that the present requirements for Outreach Paediatric Services in Central Australia outweigh the manpower resources available; hence the requirement for a review.

A further expansion of the service has been the recent addition of a Paediatric Outreach Nurse position. This has proved invaluable to service delivery, in particularly the follow-up of children, increasing the efficiency and effectiveness of Paediatric visits. This position is currently being formally evaluated for continuing funding.
Community Paediatrics

Community paediatrics can be defined as:

- the synthesis of clinical practice and public health principles directed towards providing health care to a given child, and promoting the health of all children within the context of the family, school and community;
- utilising the communities resources in collaboration with other professionals, agencies, sectors and parents to achieve optimal quality of services for all children;
- and advocating specifically for those who lack access to care because of social or economic conditions, or their special health care needs.

(RACP Chapter of Community Child Health)

The outreach service has tried to embrace these principles and provide a high quality, culturally sensitive paediatric service to children living in remote communities. It offers both a clinical service, an involvement in policy and programme development and advocating for children in CA.

Work profile

The 0-15 year olds population size for CA is approximately 3500.

- 60% Paediatric Outreach clinics to remote communities – this includes pre visit preparation, direct clinical contact with children, dictating and correcting letters, following up investigations, arranging appropriate follow up, attending meetings with other service providers. Over last year they provided approximately 800 consultations.

- The remaining 40% of time is spent on other activities including:
  - Clinics at ASH for remote children visiting Alice Springs
  - Disability/ general paediatric clinic at ASH on a monthly basis
  - Assisting the Paediatric Outreach Nurse with case management of children with poor growth
  - Meetings with other agencies re remote children e.g. FACS, Student Services etc
  - Consultations with RANs and DMOs about the management of the children in the remote communities
  - Various paediatric related committees
  - Policy development regarding Indigenous children’s health
  - Education/ teaching programme e.g. RAN orientation, AHWs etc
  - Involvement in research and other projects
  - Supervising Community Registrar and ensuring high quality training is provided

A recent review of the Outreach Services considered that:
- Each outreach paediatric visit should be for 3 days
  - For community populations 100-300 (CA has 20) 1-2 visits per annum
  - For community populations 300-500 (CA has 8) 3 visits per annum
  - For community populations 500-1000 (CA has 6) 4 visits per annum
  - For Community populations >1000 (CA has 2) 5 or more per annum

This equates to 98 clinic visits per annum (294 clinic days).

The previous incumbent to the position estimated that each clinic visit requires one day pre and post visit in preparation, follow-up etc;
Appendix B

Personnel Interviewed

I would like to thank sincerely the following for generously giving of their time and sharing with me their invaluable thoughts and experiences.

Listing of names is in no particular order or significance

Management Alice Springs Hospital
   Dr Peter Lynch  Director of Clinical Services

Paediatricians Alice Springs Hospital
   Dr Rob Roseby*  Head, Department of Paediatrics. ASH Outreach Paediatrician
   Dr Tors Clothier
   Dr Rose Fahey
   Dr Deb Fearon*  by telephone
   Dr Alina Iser   by telephone
   *Also provides ASH outreach services

Nursing staff ASH  by telephone
   Hospital Outreach Liaison Nurses
      Carmel Hatch
      Jenny Thurley
   Clinical Nurse Manager Children’s Ward ASH
      Sandy Tohe

Tennant Creek Hospital  by telephone
   Annette Pearson  Nurse Manager

Social Worker
   Sue Grant  Author of Failure to Thrive Study ASH

Paediatrician DoHF  Royal Darwin Hospital by telephone
   Dr Keith Edwards  CDC Developmental Paediatrician and Outreach Top End

Past paediatric Staff Alice Springs by telephone
   Dr Andrew White  ex Community Paediatrician CARHS from 2000 to 2008
   Dr Jacqueline Hewitt  ex Registrar ASH
   Dr Jim Thurley  ex DMO/Paediatric outreach 19  2000
   Dr John Erlich  Past Head, DOP ASH and Outreach Paediatrician

Management CARHS
   Peter Frendin  Manager CARHS
   Dr Alan Evans  Rural Medical Administrator CARHS by telephone
   Ms Michelle Evison-Rose  Manager Nursing Services CARHS by telephone

Primary Care Physicians CARHS
   Dr John Hester
   Dr Stephen Foster
   Dr Louise Elliot

Outreach Community Paediatrician CARHS
   Dr Clare MacVicar

Paediatric Outreach Nurse CARHS
   Elise Rolfs
Review of Community Paediatrics CARHS

Staff at CARHS Office Alice Springs
Jill Taylor Administrative Assistant at CARHS Alice Springs. Additional thanks for coordinating the logistics of appointments and the Reviewer's visit to AS
Jane Jessif Secondment to CARHS and Recent MSOP coordinator ASH
Ross Cole Aboriginal Health Worker

Remote Field Staff CARHS by telephone
Trish Robbins HCM Ali Curung
Lyn Byers HCM Docker River
Marjorie Van der Linden HCM Hermannsburg
Margie McLean HCM Elliot
Teleconference telephone link up with Health Centre Managers from CARHS in Alice Springs

Allied Health Professionals Alice Springs Flynn Drive
Merren Weaver
Raf Abdul Rashid

Remote Allied Health Alice Springs
Aged and Disability Services Barkley Region
Erica Whitehead

Management ACCHS by telephone
Paul Quinlivan Administrator Ampilawija
Scott Campbell-Smith WYN Health Service Yuendumu
Sarah Doherty CEO Utopia Health Service
Dr Colin Marchant Acting Medical Administrator CAAC Alice Springs
Dr Liz Moore AMSANT Alice Springs
Bill Mells Nurse Manager Anyinginyi Health Service Tennant Creek

Primary Care Physicians ACCHS by telephone
Alex Hope Santa Theresa Health Service
Kerry Gell Nganampa Health Service
Frances Poliniak Hermannsburg
Dr. Liz Moore, Aboriginal Medical Service Alliance Northern Territory. Survey of ACCHS doctors by email.

Centre for Remote Health by telephone
Sabina Knight Senior Lecturer Remote Health Practice and CRANA Fellow

Maternal Child and Youth Health Program
Dr. Barbara Paterson Manager
Merrilee Baker Child Health Nurse
Sylvia Palmer Child Health Nurse
Ruth Primrose Child Health Nurse

Child And Adolescent Mental Health Services, by telephone and correspondence
Emma Hartley Child and Adolescent Psychologist

Mental Health Services Alice Springs
Dr. Marcus Tabart Outreach Psychiatrist Alice Springs, by telephone.
Appendix C

Background information resources:

Indigenous Access to Core PHC Services in the NT Technical Working Group Paper on Remote PHC Core Services 2007


Background briefing document Community Paediatric Review CARHS April 2008

Historical background of outreach paediatric service CARHS April 2008 accompanying the Review Commissioning Document


Community Paediatricians outreach report CARHS 2005-06

Visiting schedules of both CARHS Community Paediatricians 2005-6

Visiting schedule of Top End Paediatricians to Communities 2007


Response to the Position Statement by Dr. Rob Roseby Head of Department DOP ASH March 2008

Evaluation of the Paediatric Outreach Nurse CARHS April 2008

Strategic Plan of the Department of Paediatrics (DOP) Alice Springs Hospital (ASH) 2005

Terms of reference for review of the Clinical Organization and Management of the DOP ASH April 2008

Table of communities visited, child population under 16 yrs, date of last visit, ideal current expected frequency, mode of transport at Feb 2008. Elise Rolfs CARHS

Email and correspondence from stakeholders.
Appendix D

Performance Indicators

2a. The adherence to a planned fixed visiting schedule is central to the leadership and integrity of personnel in their service commitment and advocacy for remote indigenous children. If this parameter falters so will any interventions associated with the service. Adherence brings predictability, the possibility of better organization and coordination/integration with other services, distribution of load for the local staff, encourage forward planning of other rosters and commitments such as on call, teaching, supervision and work/life balance. It will allow planning for locum support and contingency plans where clashes of priority occur. It allows planning of efficient sharing or use of other support staff such as Paediatric Outreach Nurses, Hospital Outreach Liaison Nurses, and of transport facilities including charter of aircraft. Engagement with other service personnel will be more predictable.

This is the most important of the performance indicators. Visits should be negotiated with communities at the planning stage with open discussion and agreement regarding the content and expectation of the visits. As a default for frequency of visits the ideal would be at a minimum of 3-6 monthly for smallest communities and 2-4 monthly for the largest with duration of 1 to 4 days. The specified dates for visits should then be fixed. Where there is a resource deficit as is the case currently, the frequency may progressively be dropped by one visit a year to each community and if not resolved then by shortening a day per visit or conversely shorten visits first then frequency according to circumstances prevailing. Small communities may have to be abandoned.

Should a visit face cancellation an alternative paediatrician should be available to deputise by internal negotiation or a locum with experience in Central Australian paediatrics employed. If resource recruitment fails and visits are modified, a phone review service for the community’s patients should be arranged and an alternative visit arranged at the earliest date possible.

Performance measurement is degree of success in meeting this schedule acknowledging the difficulties involved and need for compromise.

2b. A planned and scheduled program of activities developed for visits to communities integrating with other visiting and local resources having components of clinical service, education, health promotion and community development. The Plan would be considered part of performance achievement, developed and revised annually. The scheduling of visits would be a network and team building exercise for all outreach paediatricians and representatives of the wider group of related remote visiting services personnel regardless of line management and undertaken yearly with a strict agenda in a venue away from the work environment. Important stakeholders should include all visiting paediatricians, outreach nurses, representative DMOs, ACCHS’s, RANs, Allied Health, CAMHS, MCYH and other remote visiting professionals.

Measurement of this indicator by default would be attendance at and contribution to the planning and program development of the schedule as evidenced at performance appraisal.

2c. Community clinic attendance of requested (listed) patients measured against DNA’s.
A measure of stability suggesting engagement by the paediatrician and acceptance by the community. It also reflects the organisation and communication between Hospital, the outreach services, community and local Health Service.

Performance would be percentage success of expected patient (listed) attendance in the community.

2d. Case notes completed legibly and having a clear management plan. The letter of consultation with results of tests or promised action communicated to the appropriate health representative arriving in a timely manner.
A measure of level of care, commitment to outreach, support of PHC staff and community. Also a measure of administrative support to the paediatrician.

Performance is compliance found in randomly selected charts performed yearly prior to Performance appraisal.
2f. An audit of compliance with management and prophylaxis of chronic disorders through a planned and scheduled review of community charts annually. A measure of engagement, education, communication and monitoring with local staff.

Performance would be the number of charts reviewed as having an appropriate action plan made to address any deficiencies of care as a percentage of children with a known condition in the paediatrician's area. Yearly
e.g. Chronic respiratory disease, Rheumatic Fever, Renal disease, Obesity, Diabetes Mellitus, Disability, FAS, CP, Severe mental health issue, FTT.

2g. An audit of a clinical parameter such as haemoglobin level, urinalysis, growth measurement

Performance measured against a criteria set and action taken. Reported annually at performance appraisal.

2h. Immunization programs in place and successfully implemented in communities visited.
A measure of support for public health, community organization and function.

Performance, the % immunised by inspection of random records or community data routinely collected. Yearly

2i. Community & other professional education. A committed negotiated plan with the community health centre to teach informally and formally as part of consultations and case management.

Evidence of engagement by random survey of health services and reported at performance appraisal.

2j. Community engagement
Practice paediatrics in the context of supporting ownership of health problems by family and community and their active part in developing solutions.

Engage AHWs in consultation and teaching whenever possible acknowledging and utilizing their skills in language, cultural expertise and natural networking to enhance health literacy and promotion.

Visiting and consulting with teachers at the community school and leaders of early education programs etc. Engage community management by meeting yearly.

Performance: Document engagement in community meetings and consultations. E.g. discussion about prevalent conditions. Evidenced at performance appraisal.

2k. Satisfaction surveys of communities visited.
A measure of communication and relationship with the community and its health service providers.

Performance: a feedback of satisfaction with the service on sampling by questionnaire for Health Care Managers and Community Council at several different sized communities prior to performance appraisal.

2l. Agency and professional Liaison. Case Management meetings attendance:
Engagement with other services through case management and liaison meetings. FACS, Student Services, CAAC, Remote Visiting Allied Health professionals, Child Development Team, MCYH, CAMHS, NGOs Under10’s etc
Performance: compliance with scheduled plan of attendance or attendance at specific designated interagency meetings when ever in town as evidenced at performance appraisal.

2m. Program and Policy development:
Departmental and Interagency engagement. Membership of committees or program with individual, community or population well being as the objective.

Performance: compliance with scheduled plan of engagement or at least one committee membership with attendance as travel schedule allows.
2a. Teaching:
Formally in areas of expertise in paediatrics to health and other professionals at Hospital, Community, Departmental, University or for other agencies regularly.

Performance: evidenced by an agreed attendance or compliance with a scheduled plan or at least one hour a week as allowed by staffing resources.

2b. Research:
Undertaken with a focus on remote populations or remote and community paediatric issues that inform the service. Emphasis applied to service provision and outcomes/justification/effectiveness. The support of Registrar and Fellow research.

Performance: Evidence of engagement yearly at performance appraisal

2p. Personal professional development.
Paediatricians will be active and current in the RACP continuing education scheme MOPS/CME. Continue skills development in Community Paediatrics through active membership of an appropriate Community Paediatric Special Interest Group. Maintain acute general paediatric skills with currency in Advanced Paediatric Life Support and the Neonatal Resuscitation Program attending meetings informing acute and general paediatrics in the hospital and nationally.

Performance: Evidence of engagement yearly e.g. attendance at meetings etc., contribution to college discussions, papers.

2q. Hospital commitment of community paediatricians CARHS
Regular elected participation in the OPD in ASH with emphasis on improving local indigenous attendance and providing services to patients from communities. Currently there is a 60-70% non indigenous, 30-40% indigenous attendance at ASH OPD in negotiation with the DOP. Given an availability of resources, provide special service clinics e.g. Developmental, Disability, Rehabilitation, adolescent, FTT, etc in negotiation with the DOP.

Performance: compliance with scheduled plan or by default attendance at elected OPD on weeks while not travelling.

2r. Attendance at regular Hospital meetings for clinical liaison and case management
(e.g., Tues & Fri Hospital clinical and professional meetings
This measures the commitment to communication and advocacy between community and hospital and increases awareness and engagement with children who are inpatients from visited communities making possible contribution to their management and facilitating discharge planning. It may improve relationships and communication between all staff of the DOP, CARHS and communities.
Shared care of community patients in Hospital between Community Paediatrician and ASH Paediatrician may be worth considering providing it is done in a supportive collegiate manner particularly in regard to outreach visiting commitments that would have precedence to hospital priorities.

Performance: compliance with scheduled plan of attendance at meetings while not travelling.

2s. The Community Paediatrician may be interested in inpatient and on call duties electing to do so by choice.
Measure of performance in this area raises skill and compliance matters that will need negotiation and agreement between hospital team members.
The overriding agenda is that hospital needs do not impact outreach service provision by outreach paediatricians.

Appendix E
Reviewers Background

General Practitioner Kimberley Region WA with RFDS duties 1969-73
Rural and remote outreach paediatrician north and east WA 1978-
HOD Rural and Remote outreach Service WA Health Dept and 1980-
Princess Margaret Hospital for Children (PMH) Perth 1980-
General Paediatrician PMH 1980-
Neonatologist PMH 1980-