Special Commission of Inquiry into Healthcare Funding

Statement of Tracey Maisey

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Occupation: Chief Executive, Northern NSW Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**the Inquiry**) as a witness. The statement is true to the best of my knowledge and belief.

2. It is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (**MOH.0010.0542.0001**), to the extent that such topics are relevant to my role, and to the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (**MOH.0010.0541.0001**).

A. INTRODUCTION

3. I am the Chief Executive of the Northern NSW Local Health District (**NNSWLHD, District**), a role I have held since August 2023. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0607.0001**).

4. In my role as Chief Executive, I lead a team of approximately 7,000 staff to deliver healthcare across the NNSWLHD.

5. I participate in the following internal NNSWLHD committees:

   a. NNSWLHD Board and Committees - as an executive representative,

   b. Executive Leadership Team (**ELT**) – Chair,

   c. Digital Health Governance ELT Subcommittee – Chair,

   d. People and Culture ELT Subcommittee – Chair,

   e. Service Efficiency ELT Working Group – Chair,

f. Fundraising Review Advisory Committee – Chair,

g. Research and Innovation Committee – Member, and

h. Asset Management Governance ELT Subcommittee – Member.

6. I am also involved in the following NSW Health committees:

a. Single Digital Patient Record Data and Analytics Working Group – Co-chair,

b. NSW Health Cross Border Community of Practice – Co-chair, and

c. Clinical Risk Action Group – Member.

B. GOVERNANCE

7. The role and function of NNSWLHD, including my role and that of the Board, is principally set out in the *Health Services Act 1997*. NNSWLHD has adopted the latest Model By-Laws, a copy of which is exhibited to this statement (**MOH.0010.0628.0001**).

8. NNSWLHD complies with the NSW Health Corporate Governance and Accountability Compendium (**MOH.0010.0256.0001**).

9. NNSWLHD's Service Agreement with the Secretary, a copy of which is exhibited to this statement (**MOH.0100.0017.0001**), sets out the service and performance expectations of NNSWLHD for the period 1 July 2023 to 30 June 2024.

10. In addition, the following are key NNSWLHD governance documents:

a. Health Care Services Plan, Priority Focus Areas, March 2024 (**MOH.0010.0622.0001**),

b. Virtual Care Strategy 2021 – 2026 (**MOH.0010.0623.0001**),

c. Aboriginal Health Action Plan 2021 – 2026 (**MOH.0010.0614.0001**),

d. Strategic Plan 2019 – 2014 (**MOH.0010.0626.0001**), and

e. Research Strategic Plan 2019 - 2024 (**MOH.0010.0625.0001**).

11. The Creating Sustainable Futures Together (**CSFT**) Framework was launched at the NNSWLHD staff forum on 17 October 2023. I developed the program when I commenced at NNSWLHD. The CSFT Framework addresses the requirement to better enable NNSWLHD to provide innovative, integrated, and financially

sustainable patient-centred health care to the northern NSW community now and into the future. The CSFT Framework is evolving as our thinking evolves through multiple discussions with key stakeholders. A guide to the CSFT Framework will be provided to staff in the next several weeks. The CSFT Framework will also be embedded into our next iteration of the NNSWLHD Strategic Plan.

12. The CSFT Framework will support the implementation of the NSW Health Future Health Plan 2022 – 2032 and enable financial sustainability within NNSWLHD. A three-year change management program has been established to support the implementation of the CSFT Framework. During this period, the program will establish plans, systems, and processes to embed the CSFT Framework into the way we work.

13. NNSWLHD's community engagement is set out below (see Section F).

(i) NNSWLHD Board

14. The current NNSWLHD Board consists of 10 members, who bring expertise from financial, healthcare, health management, Aboriginal Health, and community perspectives. The NNSWLHD Board has a mix of skills and expertise as required by section 26 of the *Health Services Act*.

15. NNSWLHD has the following Board committees:

    a. Audit and Risk,

    b. Finance and Performance,

    c. Quality and Safety (called Health Care Quality Committee).

16. The NNSWLHD Board has also established a Medical and Dental Appointments Advisory Committee.

(ii) NNSWLHD Executive

17. NNSWLHD's ELT comprises:

    a. Director of Workforce,

    b. Director of Corporate Services,

    c. Director of Clinical Governance,

    d. Executive Director District Medical Services,

e. Director of Clinical Operations,

f. District Director of Nursing and Midwifery,

g. Director of Aboriginal Health,

h. Director of Integrated Care and Allied Health Services,

i. Director of Finance, and

j. Director of Mental Health, Alcohol and Other Drugs.

18. The ELT has established the following subcommittees:

a. Knowledge Management,

b. Health Emergency Management,

c. People and Culture,

d. Digital Health,

e. Asset management, and

f. Restricted Financial Assets Expenditure.

19. NNSWLHD is currently consulting with staff about a change to its organisational structure that involves several reporting line changes. The organisational realignment has been proposed to better enable NNSWLHD to respond to eight areas of community-based models, technology, local talent development, business intelligence, clinical leadership, simplification, efficiency, and equity of access.

20. It is proposed that this realignment will including combining the District Medical Services with Clinical Governance (currently performed by separate directorates), removal of the Integrated Care and Allied Health directorate, and creation of a Planning, Partnership and Allied Health Services directorate.

21. A new Corporate and Clinical Governance structure is also in the process of being implemented. The new governance structure is intended to strengthen the core governance principles of accountability, participation, predictability, and transparency. The structure better enables compliance with the Model By-Laws, strengthened clinical engagement within key decision-making forums and a more

efficient and effective use of resources. The key updates to the governance structure are:

a. A time limited (less than 24 months) Knowledge Management ELT Subcommittee to advance data management, analytics, use of intelligence to inform decision making, oversee data management and privacy legislation/ regulation. I will chair the Subcommittee,

b. A Medical Staff Executive Council will be established,

c. The Clinical Planning and Clinician Engagement Committee will be replaced with a District Clinical Council,

d. A specific Quality and Safety ELT subcommittee will be formed as part of this revision. This is in addition to the Board Committee in which several ELT staff and community representatives are members. Membership across the two groups will be rationalised with this change. Currently, Quality and Safety is a standing agenda item at the regular ELT meetings.

C. NNSWLHD PROFILE – GEOGRAPHY, POPULATION

(i) Geography and boundaries

22. NNSWLHD covers an area of 20,732 square kilometres and extends to the Queensland border in the north, Mid North Coast Local Health District (**MNCLHD**) in the south, and Hunter New England Local Health District (**HNELHD**) in the west.

23. The traditional custodians of the land covered by NNSWLHD are the Bundjalung, Yaegl, Gumbaynggirr and Githabul peoples.

24. NNSWLHD encompasses seven Local Government Areas (**LGAs**), as well as the Urbenville portion of the Tenterfield LGA. The seven LGAs wholly located within the LHD's area are Ballina, Byron, Clarence Valley, Kyogle, Lismore, Richmond Valley and Tweed.

(ii) Population - profile

25. The population of NNSLWHD is approximately 311,000.

26. Appendix A to the Health Care Services Plan sets out key demographic data for NNSWLHD.

27. The population is projected to grow over the coming years, increasing by 11%by 2036 from documented populations in 2016. A summary of the population projections from the 2021 Census are set out in the table below:

Age group	Population projections (number of persons) per year					Projected growth 2016-2036
	2016	2021	2026	2031	2036	
0-15 years	55,903	56,881	55,527	54,520	53,793	-4%
16-69 years	197,216	19,7869	198,083	197,610	198,240	1%
70-84 years	36,033	43,660	51,957	58,820	61,385	70%
85+ years	9,539	10,074	11,246	13,697	17,671	85%
Total	298,691	308,485	316,812	324,648	331,089	11%

28. Growth will continue to be highest in the coastal areas of NNSWLHD.

29. Along with overall population growth, the NNSWLHD population is ageing. In 2021, 17% of NNSWLHD's population was aged 70 years or over and by 2036, this is projected to increase to 24% or approximately 1 in every 4 people.

30. As set out on page 3 of the Health Care Services Plan, compared to NSW and Australian averages, NNSWLHD has:

    a. a higher proportion of people identifying as Aboriginal or Torres Strait Islander. According to the 2021 Census the percentage of Aboriginal and/or Torres Strait Islander people residing in NNSWLHD, excluding the Urbenville part of the Tenterfield LGA, is 5.2%. In NSW, the percentage is 3.4%,

    b. lower levels of educational attainment, lower median income, lower levels of people who are in full-time employment and high levels of unemployment,

    c. high levels of rental and housing stress, and

    d. pockets of high socioeconomic disadvantage (Clarence Valley, Kyogle and Richmond Valley) and advantage (Ballina and Byron).

(iii) Population – health

31. The NNSWLHD population has a higher prevalence than the state average of several disease risk factors particularly the consumption of alcohol and nicotine. However, the proportion of children achieving adequate physical activity levels is

higher than the state average. A table summary of the disease risk factors that differ materially from NSW averages, from the 2021 Census, is set out below:

	Northern NSW Local Health District	NSW
Adults Exceeding the Australian alcohol guideline (2023)	34.3%	27.1%
Adults drinking alcohol daily (2022-23)	9.4%	6.1%
Children achieving adequate physical activity levels (2021-22)	30.4%	20.5%
Adults currently smoking (2023)	15.1%	11.7%

Source: HealthStats NSW, accessed 2.07.2024. https://www.healthstats.nsw.gov.au/home

32. As set out on page 3 of the Health Care Services Plan, in terms of health status and outcomes, NNSWLHD, compared to NSW averages, has:

    a. higher rates of hospitalisation for a range of accident, illness and disease types including type 1 diabetes, fall-related injuries, intentional self-harm, acute respiratory infections and chronic kidney disease,

    b. a higher proportion of adults with mental health and behavioural problems (all LGAs excluding Ballina), chronic obstructive pulmonary disease (all LGAs excluding Ballina), current smokers (all LGAs excluding Ballina), and high alcoholic intake/more than two standard drinks per day on average,

    c. similar or higher cancer screening participation rates,

    d. higher age standardised rates of some cancer types, notably melanoma which is higher across all LGAs.

33. A summary of the prevalence of long-term health conditions in NNSWLHD including a comparison to the state average from the 2021 Census is exhibited to this statement (**MOH.0010.0630.0001**).

D. NNSWLHD HEALTH SERVICES

(i) Facilities

34. NNSWLHD has the following facilities:

    a. Hospitals: Tweed Valley Hospital; Murwillumbah District Hospital; Byron Central Hospital; Lismore Base Hospital; Ballina District Hospital; Casino and District Memorial Hospital; Grafton Base Hospital; and Maclean District Hospital,

b. Multipurpose services (**MPSs**) - Kyogle MPS, Bonalbo MPS, Nimbin MPS and Urbenville MPS,

c. HealthOne facilities: Pottsville, Coraki, and Evans Head,

d. Community Health facilities: seventeen.

35. A table setting out further details of the Hospitals and MPS, including their Modified Monash Model (**MMM**) classification, is exhibited to this statement (**MOH.0010.0619.0001**). A map of NNSWLHD and its facilities is at (**MOH.0010.0621.0001**).

36. Murwillumbah was classified as MM2 under MMM 2015, and was recategorised to MM1 under MMM 2019. Given this, Murwillumbah District Hospital is no longer considered rural and the facility is not able to offer rural student placements. The result has been that a long-standing arrangement with the University Centre for Rural Health (**UCRH**) regarding student placements is no longer viable and UCRH has withdrawn from the facility.

(ii) Health Services

37. NNSWLHD provides various community and inpatient health services. These include:

a. Acute care services: Maternal/Neonatal and Gynaecology, Planned and Acute Medicine, Elective and Emergency Surgery, Emergency and Critical Care Medicine, Child, Youth and Family Health, Cancer services, Coronary Care, Renal services, Metabolic obesity service, Geriatric services and Stroke care,

b. Sub-Acute Care: inpatient and community-based rehabilitation services, inpatient and community palliative care, and Aged care services,

c. Aboriginal health services (see Section G below),

d. Ambulatory and Community Care: Allied heath, BreastScreen, Child and family health, Chronic disease management, Community Nursing, Hospital in the Home services, Dental and oral health service, Men's health services, Palliative care, Specialist Outpatient Clinics, and Voluntary assisted dying,

e. Mental Health, Alcohol and Other Drugs (**MHAoD**) - Inpatient and community health services,

f. Public Health – Communicable disease management, Immunisation, Environmental Health, Epidemiology and public health. This is hosted by MNCLHD,

g. Sexual health services, Violence, Abuse and Neglect services,

h. Clinical Support Services - Imaging services, Pathology, Pharmacy, Patient Flow and Transport, and

i. MPSs – deliver emergency, sub-acute and Residential Aged Care Services.

38. NNSWLHD operates as a networked structure which provides improved opportunities for recruitment of clinical workforce (particularly smaller facilities), better communication and interaction with the community, and clinical governance to support the provision of safe and high-quality care at an appropriate role delineation level.

39. Clinical networking is organised around a 'hub and spoke' model with Lismore Base Hospital, Tweed Valley Hospital, and Grafton Base Hospital as the 'hubs' for their respective valleys.

40. MHAoD and Community Health are District wide services. They have District service teams that have local management within the Tweed, Richmond and Clarence valleys.

41. Emergency Department (**ED**) presentations in NNSWLHD over the last three financial years is set out in the table below:

Year	Number of ED Presentations	% change from prior year
2021/2022	211,836	Excl. as prior year impacted by Covid
2022/2023	220,734	4.2%
2023/2024	229,587	4.0%

42. ED presentations in the January to March 2024 quarter were the highest on record in NNSWLHD, at 58,832.

43. There were 74,936 admitted patient separations in NNSWLHD hospitals in 2022/23. Separations increased 5.1% from 2021/22. The predominant growth has been in procedural and surgical separations.

44. There were 31,775 operations at NNSWLHD hospitals in 2023/24. Total operations increased 1.5% from 2022/23 (31,303 operations).

45. There were 2,702 births at NNSWLHD hospitals in 2023/24. Births increased 1.4% from 2022/23 (2,666 births).

46. There were 531,547 non-admitted patient service events at NNSWLHD hospitals in 2022/23.

E. CAPITAL WORKS

47. Major capital works from the last few years include Tweed Valley Hospital (**TVH**) and Lismore Base Hospital (**LBH**).

48. TVH at Kingscliff was a project from 2019 - 2024. This was a project to replace the old Tweed Hospital with a new hospital that was built considering future population growth. The project cost was $723 million. TVH has a gross floor area of more than 71,000 m2 and is located on 19.4 hectares. This is approximately three times the size of The Tweed Hospital.

49. TVH commenced service delivery on 7 May 2024. Currently TVH utilises just under 300 beds. TVH has been built with a total capacity of 430 beds. There are a total of 12 operating theatres, seven of which are currently being used.

50. The transition model was organised around three phases: 'move, settle, grow' with some exceptions. Additional ED and MHAoD capacity was opened from day one, along with approximately 50 additional beds in excess of those in use at the Tweed Hospital. Radiation Oncology services have now commenced. Cardiac catheterisation services are planned to start late September 2024. Approximately 320 staff were employed to open this additional capacity. This includes additional cleaning, maintenance, and orderly staff due to the size of the new facility.

51. Further service capacity will become available over time as demand and the associated funding for additional services allows.

52. LBH was a ten-year project from 2013 to 2023. The redevelopment of LBH has continued through several stages, with the most recent being Stage 3C. The total project cost was $312 million. Stage 3C included a refurbished medical ward, new

outpatients department, and a new cardiology unit, with co-located coronary care beds and step-down cardiology beds in the one unit, making it easier for staff to provide ongoing care to these patients.

53. Planning is currently underway for the Grafton Base Hospital Redevelopment. The NSW Government has committed $263.8 million to this project.

54. For the 2024/2025 financial year NNSWLHD has submitted seven proposals under the Regional Health Minor Works Program to further upgrade its facilities.

55. In addition to this, NNSWLHD has submitted ten Capital Investment Proposals for more significant upgrades. These relate to:

    a. Ballina District Hospital – refurbish and redevelop critical areas and support expanded capacity to meet demand, pending full redevelopment,

    b. Casino and District Memorial Hospital – proposal to convert the vacant ward into residential aged care beds under MPS provisions,

    c. Grafton Base Hospital – an interim ED Short Stay Unit prior to delivery of the broader redevelopment, and key worker accommodation (this includes a proposal to refurbish the Grafton Correctional Centre into group accommodation and multi-bedroom apartments),

    d. LBH – Crawford House rebuild, refurbish and redevelop the mental health campus, and stage 3D redevelopment covering back-of-house and support services,

    e. Maclean District Hospital – acute ward refurbishment, new integrated medical imaging department (including a CT), and

    f. Urbenville MPS – a greenfield redevelopment.

F. COMMUNITY ENGAGEMENT AND SUPPORT

56. The NNSWLHD community engagement framework was published in 2019, *Partners in Health, A Community Engagement Framework for Northern NSW Local Health District* (**the Community Engagement Framework**), a copy of which is exhibited to this statement (**MOH.0010.0611.0001**).

57. The NNSWLHD community engagement structure is set out on pages 12 and 13 of the Community Engagement Framework and includes:

a. A Community Partnership Advisory Council (**CPAC**) to oversee community engagement across NNSWLHD. CPAC is an executive committee which includes representatives from each advisory group, the Chief Executive, Clinical Operations Director, Associate Director Planning, and four Board members,

b. Community Advisory Groups: Tweed, Murwillumbah, Byron, Ballina, Lismore, Casino, and Clarence,

c. Community Service Groups: Ngayundi Aboriginal Health Corporation, Mental Health Forum, Drug and Alcohol Advisory Committee, and MPS Network Community Consultation Forum, and

d. Special interest groups and targeted improvement groups, including the Health Literacy Steering Committee, Health Care Quality Committee, and Diversity Inclusion Steering Committee.

58. Community Advisory Group members provide input and feedback to NNSWLHD. Community members can contribute opinions and share experiences to improve health services and use their networks to gather and distribute information. The advisory groups and CPAC monitor safety and quality performance, patient feedback and contribute to a wide range of LHD projects and processes including working groups, safety and quality committees, recruitment panels, patient information reviews, patient surveys and wayfinding audits. Terms of reference are in place for all advisory groups and are reviewed annually. A copy of the Terms of Reference for the CPAC is exhibited to this statement (**MOH.0010.0617.0001**). A copy of the Terms of Reference from one of the Community Advisory Groups, Tweed, is exhibited to this statement (**MOH.0010.0631.0001**).

59. During COVID, the former Chief Executive hosted monthly community forums to provide updates on the COVID situation to Community Advisory Group members.

60. An evaluation survey of our Community Advisory Groups in December 2023 recorded an average member experience rating of 8.3 (out of 10), up from 8.0 in 2022. The results showed that advisory group members are engaged and positive about their experience. Members consider Community Advisory Groups to be a good mechanism for NNSWLHD to connect with the community. Meetings are operating well and administered effectively and the majority of members were

able to identify achievements/contributions. A copy of the results of the evaluation is exhibited to this statement (**MOH.0010.0612.0001**).

61. Health service planning is a standing agenda item on the CPAC.

62. During 2023/24 there was comprehensive staff and community consultation in the development of NNSWLHD's Health Care Services Plan.

63. NNSWLHD is planning to deploy the Social Pinpoint digital engagement platform which will help to gather insights from a broader cross section of the community in a more efficient manner and through new channels. The proposal was tabled at CPAC and received strong support from community representatives.

64. CPAC members were recently invited to the NNSWLHD Leadership Summit, which is an annual event. This is the first-time community members had been invited to attend.

65. By way of Board oversight, community engagement updates are provided to the Health Care Quality Board Committee. Board meetings are also held across the District and key stakeholders (local Members of Parliament, Mayors, LGA General Managers) are invited to meet with the Board.

66. NNSWLHD hosts an Annual Public Meeting which includes a Board presentation and Question and Answer session with community attendees (online and in-person). Community Advisory Group members are invited to attend the Annual Public Meeting and other forums and events. Members of the community are also invited to the Annual Public Meeting.

67. NNSWLHD's new Healthcare Helper volunteer program was launched in February 2022. There are currently 41 volunteers volunteering regularly within our health facilities and 96 people are currently moving through the recruitment and screening process.

68. NNSWLHD also has a long history of working with partners to support fundraising activities. This includes the United Hospital Auxiliary North Coast branches who have hundreds of members actively fundraising for NNSWLHD. The Murwillumbah Coffee Shop volunteer group also works tirelessly to raise funds for its hospital.

69. NNSWLHD is currently conducting a review into our fundraising efforts and processes. This review includes the work of Our Kids, a well-supported cause in

the community since 2001. Our Kids is a NNSWLHD charitable trust that raises funds to purchase paediatric equipment for local hospitals.

G. ABORIGINAL HEALTH SERVICES

70. The NNSWLHD Aboriginal Health Action Plan 2021 – 2026 sets out the current NNSWLHD strategy to address the health disparities between Aboriginal and non-Aboriginal people. The four priority areas are:

    a. Strengthening and growing the Aboriginal Workforce through enhanced career development supports and increasing workforce participation that will allow us to create a more skilled talented workforce,

    b. Enhancing our partnerships by focusing on building on our existing relationships and creating new internal partnerships that will allow us to work better as an organisation,

    c. Providing culturally safe environments to ensure we can provide safe considered care to our patients and provide opportunities to our staff to enhance their cultural knowledge to ensure improved services, and

    d. Ensuring seamless planning and service delivery by delivering projects that are focused on empowering Aboriginal communities to achieve healthier lifestyles.

71. The Terms of Reference for the NNSWLHD Aboriginal Health Steering Committee, which is overseeing the implementation of the Plan is exhibited (**MOH.0010.0632.0001**).

72. The Aboriginal Health Directorate at NNSWLHD is comprised of 31 full-time equivalent (**FTE**) staff, including:

    a. 6 Aboriginal Health Leadership positions,

    b. 3 Senior Manager positions,

    c. 15 Aboriginal Health Workers,

    d. 3 Clinical Nurse Specialists in Chronic Care, and

    e. 4 Aboriginal Health Workers in Chronic Care.

73. The core function of the Aboriginal Health Directorate is to deliver tailored Aboriginal health services, which includes healthy lifestyle programs, cultural

support, health education and promotion, chronic care management in the home, and strategic planning (including engagement and empowering Aboriginal communities in the process), implementing the 'Respecting the Difference' cultural framework, reporting, and leadership and advice on Aboriginal workforce initiatives.

74. In terms of providing culturally safe environments, at NNSWLHD 64% of staff have completed Respecting the Difference (**RTD**) training, a significant increase at NNSWLHD over the last 5 years. Work is underway to implement flexible and innovative delivery options, including RTD as part of orientation, and RTD delivery outside of standard hours to suit rosters. At NNSWLHD, there is an Aboriginal educator on staff. This works well, however there is no funding for an additional Aboriginal educator role which is needed.

75. In addition, the NNSWLHD Aboriginal Health Impact Statement Advisory Committee identifies if resources have appropriate health literacy, and if not refers the resources to the Health Literacy Team.

(i) Examples of services

76. The Rheumatic Heart Disease Project was developed to raise awareness, improve knowledge, and develop referral pathways for diagnosis, treatment and prevention of Acute Rheumatic Fever and Rheumatic Heart Disease (**RHD**).

77. Strengthening the diagnosis, notification and follow up of RHD is a priority under the Better Cardiac Care for Aboriginal and Torres Strait Islander People. The Better Cardiac Care for Aboriginal and Torres Strait Islander People initiative is part of the Australian Government's commitment to closing the gap.

78. Patient audits undertaken in Northern NSW during 2021 by Aboriginal Medical Services (**AMS**) identified a significant number of previously unknown cases of RHD. Numbers indicated the condition is potentially endemic for Aboriginal people in Northern NSW.

79. The Rheumatic Heart Disease Project involved the development and implementation a new Clinical Pathway and educational program for clinicians and community, significantly enhancing the prevention of RHD. This initiative promotes early diagnosis and effective management, ultimately improving patient outcomes and reducing disease prevalence.

80. Recurrent funding has not yet been confirmed.

81. The Partnership ED DNW (Did not Wait) Project focuses on reducing the number of Aboriginal patients who leave the ED without being seen. By improving patient engagement and providing culturally sensitive support, this initiative aims to enhance access to timely care, leading to better health outcomes and increased trust in healthcare services

82. The Aboriginal community has identified several health priorities, such as concerning vaping behaviours within youth. This has identified a gap in the availability of culturally appropriate health resources. The NNSWLHD Aboriginal Health team are now working on Aboriginal specific vaping resources that meet health literacy standards and include content that has been requested by community members. This will be used in school and community-based education.

83. Some other examples are:

    a. Aboriginal Health Promotion (**MOH.0010.0615.0001**),

    b. Aboriginal Chronic Care Program (**MOH.0010.0616.0001**),

    c. Aboriginal Palliative Care Service (**MOH.0010.0627.0001**),

    d. Aboriginal Hospital Liaison Officer (**MOH.0010.0613.0002**),

    e. Finding your Way Model of care. This model is a holistic shared decision--making model, where Aboriginal people and their healthcare professionals make decisions together. Staff within our LHD utilise this model in the delivery of our Chronic Care for Aboriginal People Program. Further information about this model of care is at https://aci.health.nsw.gov.au/shared-decision-making, and

    f. The Aboriginal Maternal Infant Health Service at Lismore, Casino, and Clarence Valley. This sits within Community Health.

(ii) Partnerships and community engagement

84. A key component of delivery of Aboriginal health services is working with partners to ensure Aboriginal voices are embedded in the services NNSWLHD delivers. NNSWLHD has strong partnerships and community engagement via:

    a. The CPAC has two Ngayundi representatives and the Aboriginal Engagement and Governance Manager,

b. Two Aboriginal representatives on each Community Advisory Group,

c. The Ngayundi Aboriginal Health Council within the Community Engagement Framework,

d. There is a newly endorsed Memorandum of Understanding (**MOU**) between Bulgarr Ngaru Medical Aboriginal Corporation (**BNMAC**) and the LHD Chronic Care for Aboriginal People (**CCAP**) program (**MOH.0010.0620.0001**). The purpose of the MOU is to outline terms of engagement and shared ways of working between the services that are provided in partnership with BNMAC and NNSWLHD CCAP team, to enhance the clinical service provision to the Aboriginal community in a culturally safe way.

e. A Northern NSW Aboriginal Health Partnership has been in operation in NNSWLHD for several years. The current agreement is between BNMAC, Bullinah Aboriginal Health Service, Rekindling the Sprit, and Healthy North Coast Ltd (the Primary Health Network, **PHN**). The partnership seeks to improve outcomes for Aboriginal people across NNSWLHD through providing a forum where the partners may consult, advise and negotiate on matters relevant to Aboriginal Health. A new partnership agreement has been negotiated and is currently being signed by the parties.

(iii) Opportunities and barriers

85. At NNSWLHD, the following works well: Aboriginal inpatient brochure packs distributed across the LHD, the Flu messaging program to CCAP clients, established clear referral pathways between AMSs and CCAP, inclusion of Aboriginal Health Workers in the CCAP care team, family and community involvement, regular follow ups, and engagement with the Aboriginal Health Leadership Team, and maximising the use of data (for example, census, Bureau of Health Information patient experience data, and the Aboriginal Cultural Engagement Self-Assessment Audit Tool).

86. The main barriers are:

a. All occasions of service are non-billable within the CCAP model of care because we received block funding for our Aboriginal services and we do not currently have practitioners that have billable capacity. The introduction of a Nurse Practitioner model would enhance capture of revenue,

b. Programs are often time limited with funding restrictions which reduce the opportunities for community engagement, input and reviewing or feedback of programs,

c. Where the burden of disease for Aboriginal People is above 40% this should warrant an Aboriginal specific program with Aboriginal Key Performance Indicator employment statistics to match.

H. AGED CARE SERVICES

87. NNSWLHD operates the following residential aged care beds:

Facility	Actual Bed Utilisation 23/24
Bonalbo MPS	15
Kyogle MPS	23
Nimbin MPS	10
Urbenville MPS	17

88. Due to the damage from the floods experienced in 2022, Green Hills Lodge at Murwillumbah (36 residential aged care beds) and Fromelles Manor at Lismore (63 aged care beds) were closed and have not reopened.

89. Australia wide, recent closures of residential aged care facilities have been driven by multiple factors, including Australian Government reforms (such as the requirements for 24/7 registered nurse coverage), workforce shortages, and changes in bed demand within smaller rural communities as residents move from the area and the overall population reduces.

90. The Australian Government uses a needs-based planning framework and an aged care provision ratio to ensure sufficient supply of aged care places to match current and future need. The current aged care provision ratio, from 2024/25, is 60.1 places per 1,000 eligible population (the eligible population includes non-Indigenous people aged 70 years and over and Aboriginal people aged 50 years and over).

91. Based on the ratio of 60.1 places per 1,000 eligible population, there is an under-supply of 477 places across NNSWLHD, based on the projected population in 2026.

92. NNSWLHD monitors the number of patients that are waiting for transition to residential aged care from a hospital via the Patient Flow Portal. To be classified as 'waiting', patients must already have spent 35 days in hospital, meaning there

is a long length of stay for these patients who may be more appropriately cared for in an aged care setting. On 3 September 2024 there were 61 patients (approximately equivalent to 2 medical wards) in NNSWLHD facilities waiting to be transitioned to a Residential Aged Care Service.

I. COLLABORATION WITH NSW HEALTH, QUEENSLAND HEALTH, PHN, EXTERNAL PARTNERSHIPS & EDUCATIONAL PARTNERSHIPS

(i) NSW Health Partnerships

93. As the Chief Executive of NNSWLHD, I attend a monthly Senior Executive Forum, which brings together the Secretary of Health, the Ministry of Health Deputy Secretaries and Chief Executives of Local Health Districts and Specialty Health Networks from across the state to consider health issues of system-wide interest.

94. I also attend a monthly meeting of the Rural and Regional LHD Chief Executives hosted by Regional Health. This includes a review of progress against the Inquiry into *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales* recommendations, and matters of particular interest to rural and regional LHDs.

95. The *NSW Health and NSW Primary Health Networks: Working together to deliver person-centred care, Joint Statement* was executed in 2021. The Joint Statement sets out how NSW Health, the PHNs and the Commonwealth will work together as one health system. On 16 February 2024, NNSWLHD entered a Board level MOU with Healthy North Coast Ltd and MNCLHD. This MOU is the articulation of the commitment of the Parties to localise the intent of Joint Statement in the North Coast. A copy of the MOU is exhibited to this statement (**MOH.0010.0585.0001**).

(ii) Queensland Health partnerships

96. I understand that prior to COVID 19, NNSWLHD and the Gold Coast Hospital and Health Service regularly engaged in cross border executive meetings. In addition to my role as Co-chair of the NSW Health Cross Border Community of Practice, in the coming months NNSWLHD will seek to reimplement regular operational cross border meetings which will include discussing planning and strategic and operational matters. This will be within the umbrella of the recently signed interstate agreement between NSW and Queensland Health.

97. Notwithstanding the above, the NNSWLHD Patient Flow Unit and local clinicians continue to have frequent discussions with the Gold Coast Hospital and Health

Service Patient Flow Unit regarding patient transfers to and from the Gold Coast University Hospital.

98. From time to time, doctors who work for the Gold Coast Hospital and Health service undertake a rotation at a NNSWLHD facility.

(iii) External Partnerships

99. The First 2000 Days Project (**Project**) in Northern NSW is a partnership between Tresillian Family Care Centres, NNSWLHD, Healthy North Coast (North Coast PHN) and BNMAC.

100. The Child and Family Wellbeing Hub is delivered as part of the First 2000 Days Project in Northern NSW. The Project focusses on wellness and early intervention, and the collaborative implementation of identified strategies with joint funding, to improve health and wellbeing outcomes for children aged 0-5 years, and their families.

101. The Child and Family Wellbeing Hub is focussed on providing supports to families in the Clarence Valley, living on Gumbayngirr, Bundjalung and Yaegl lands.

102. NNSWLHD also has partnerships and/or affiliations with:

a. Momentum Collective – for psychosocial supports and supported accommodation. This is to promote community recovery, a pathway to social housing, and to reduce readmissions and/or ED presentations,

b. Open Minds – a Housing and Accommodation Support Initiative (**HASI**) and Community Living Supports (**CLS**). This is a program for tenancy support and maintenance. The aim is to prevent and reduce homelessness, promote recovery, and reduce readmissions and/or ED presentations,

c. Wellways – a HASI and Youth Community Living Service – it provides support to an individual, group, family and carer of a person with mental health symptoms. The aim is strengthen community supports and reduce carer burnout,

d. The Buttery is a 24-bed Alcohol and Other Drugs Residential Rehabilitation and Magistrates and Early Referral into Treatment (**MERIT**) residential facility. The aim is to provide early treatment, engagement, and recovery,

e. Namatjira Haven – two Aboriginal Male MERIT beds, which provides Aboriginal specific early treatment, engagement, and recovery,

f. GROW – supports groups in the community and provides education sessions within Mental Health Inpatient Units. The aim is for peer led recovery and development of support networks in the community to sustain recovery,

g. Healthy North Coast Ltd – the PHN, as set out above,

h. NSW Housing – engagement and education and complex care planning for shared clients. This includes MHAoD priority nominations rights for a small number of NSW Housing properties. The aim is to support clients to maintain tenancies and identify, plan, and treat early symptoms to reduce risks to tenancies and possible hospital admissions.

103. Other partnerships are set out above in the section on Aboriginal health services.

(iv) Education Partnerships

104. The UCRH in Lismore is the focal point of NNSWLHD's relationships with the University of Sydney, University of Western Sydney, and University of Wollongong. Those universities collaborate in most student clinical placements in the Richmond and the Clarence Valleys, although students from approximately 20 other institutions also receive some placements, through approved Student Placement Agreements. The three major universities also collaborate in Richmond and Clarence Valley Regional Training Hubs, funded by the Commonwealth to pursue enhancing the placement of students in regional and rural areas, with the aim of their eventual employment as professionals in those non-metropolitan areas.

105. The NNSW Academic Health Alliance (**the Alliance**) consists of a collaboration between Griffith University, Bond University, Southern Cross University and TAFE NSW. Those organisations provide most student clinical placements in the Tweed Valley. Due to the non-rural status of the Tweed area, there is no Commonwealth-funded regional training hub. Those universities and TAFE have funded the construction of a Learning Development and Research centre floor on the TVH campus, from which they manage their Tweed Valley placements, and also engage with their other relationships with NNSWLHD including conjoint academic/research positions. The relationship between NNSWLHD and the Alliance is governed by a 15-year Agreement which commenced in 2024.

J. CHALLENGES AND OPPORTUNITIES – DELIVERY OF SERVICES

106. Compared with state averages, the NNSWLHD community is older, has higher levels of disadvantage, and has higher rates of certain disease and chronic conditions as well as disability. Chronic disease and multimorbidity prevalence are projected to continue to increase, and with people living longer, demand on health services will grow at rates that outpace population growth. This will challenge system sustainability into the future.

107. Equity in access and outcomes is also challenged by a range of factors including poorer overall health (including what is driven through the social determinants), workforce constraints and the rurality of some areas of the LHD.

108. Addressing the noted health challenges and meeting the health needs of the NNSWLHD community requires innovation, shifts in investment towards community, ambulatory and in home service delivery, in active partnership arrangements with health and social organisations, and communities.

109. More of the same is not the answer. Step change is possible (as demonstrated particularly throughout COVID-19) and incremental steps to delivering care in different ways will continue to be a strong focus to achieve sustainable change.

110. The refinement of current and implementation of new service models is already occurring to deliver value-based healthcare, which in NSW Health is defined as the equitable, sustainable, and transparent use of the available resources to achieve better outcomes and experiences, for every person at all stages of their health journey. Examples of value-based care in NNSWLHD include:

    a. Enhanced hospital in the home (HITH),

    b. Geriatric outreach services,

    c. Knee and hip arthritis service,

    d. Renal support, and

    e. Direct Access Colonoscopy.

111. In March 2024, NNSWLHD finalised the Health Care Services Plan which outlines priority areas and actions for service development over the coming years. Across all seven priority areas, actions relating to service model changes are outlined,

with a strong focus on sustainable and value-based healthcare delivery. The seven priority areas are:

a. The implementation of a clinical streams model in NNSWLHD to drive improvements in equitable access to care, consistent and coordinated approaches to care, staff and patient experience, and efficient use of resources. A clinical stream model is where a LHD wide, rather than a facility-based, approach is taken to managing a service. In NNSWLHD, the MHAoD service is an example of a clinical stream model.

b. An enhanced focus on delivering more care outside of hospital settings (ambulatory care) with a focus on partnership approaches, service integration across healthcare settings, and virtual care.).

c. Finding sustainable solutions for services that are vulnerable to fluctuations in workforce or demand (generally low volume high complexity care).

d. Undertaking joint planning with MNCLHD and Healthy North Coast PHN to deliver and implement a joint regional MHAoD and Suicide Prevention Plan.

e. Improving equity of access to Aboriginal and Torres Strait Islander communities through the implementation of culturally appropriate service delivery models and culturally safe practice.

f. Implementing novel and additional services for older patients that are focused on their stage of life.

g. Reviewing the role of facilities as well as the sustainability and viability of services that operate across the LHD. How these services and facilities function, integrate with other areas, and meet the needs of the population, will be considered in a contemporary way to ensure that future planning and service delivery addresses the health needs of NNSWLHD communities and improves access and outcomes of care.

F. FUNDING

(i) Funding types

112. All eight hospitals within NNSWLHD are funded on an activity basis. For the 23/24 financial year the total activity-based funding (**ABF**) for NNSWLHD was $868 million.

113. Our four MPS facilities are block funded. MPSs receive block funding based on costs prior to the Covid pandemic plus nominal escalation. The Commonwealth and the State have agreed to pool funds. Other income is derived from aged care fees, accommodation charges and Medicare payments for non-admitted services provided at MPS sites with an exemption under section 19(2) of the *Health Insurance Act 1973* (Cth).

114. The Commonwealth's contribution, the State's contribution and other income are collectively referred to as the 'Pooled Funding' and these must be used by the MPS for the provision of aged care services (residential care, residential respite care, home care) and health care services (acute, emergency, sub-acute, primary, allied health, and community care).

115. Hospital avoidance interventions are delivered in the community and so are eligible to receive funding linked to the number of non-admitted services performed. This is up to the level funded under the service agreement.

116. There is clear evidence that real healthcare disparities exist between rural and urban Australians and that rural and regional populations receive significantly less funding per capita than urban communities. For rural and regional areas categorised as MM2 – MM5 (in which approximately 76% of the NNSLWHD population resides) the funding gap is estimated at $851.96 per capita (12%) as documented in the Evidence Base for Additional Investment in Rural Health in Australia National Rural Health Alliance June 2023. Public hospitals account for $348.46 of this. For a total population of 237,815 within the MM2 – MM5 catchments within the LHD, this represents a disparity of approximately $83 million.

117. The NSW Health funding model provides that patients residing or receiving treatment in outer regional, remote and very remote areas are eligible for ABF price weight adjustments to reflect the additional cost of providing services in these areas. However, this does not benefit NNSWLHD as our towns of Urbenville and Bonalbo which might otherwise be eligible for the weight adjustment are both serviced by MPS facilities which are not funded under the ABF model.

(ii) Financial performance

118. The NNSWLHD's 2023-2024 initial expense budget was $1.08 billion, which is an increase of $99 million or 10.1% on the 2022-23 annualised budget.

119. The above budget includes 6-month funding for the opening of TVH in May 2024. Staff profiles have been based on award requirements and minimum staffing levels, with step increases as demand requires. For a facility that is growing, staffing levels will not be optimised until patient volumes reach a viable level. For example, radiation oncology and cardiac catheterisation services have step phased increases to ensure systems and technologies are rigorously tested in a phased approach.

120. From a financial perspective this means that the service will be in deficit until activity thresholds are achieved. A forward funded plan for TVH is still to be negotiated.

121. Prior to COVID and the floods in 2022, NNSWLHD was generally on budget. Since this time, the NNSWLHD has recorded deficits. In June 2023 the deficit, excluding one off funding for premium agency use related to the flood response, was $109 million. The unmitigated forecast was a deficit of $135 million by June 2024.

122. The end of year 2023/2024 position was $74 million deficit. This is a turnaround of $61 million in 12 months. This has been achieved through:

    a. Delivering an efficiency improvement program of $48 million. Of this, $40 million was due to reduced cost and utilisation of premium labour.

    b. One off program / recruitment slippage of $9.9 million and reimbursement for activity over target.

123. In prior years. LHDs were able to accrue up to 4% above the service agreement targeted levels, at 40% of the National Efficient Price. Funding is not withdrawn for activity not delivered to service agreement levels.

124. NNSWLHD has had year on year activity growth in services that are predominately demand driven (emergency and acute presentations), and the additional 'extra' funding equated to approximately $7 million revenue for NNSLWHD in the 2023/2024 financial year.

125. This financial year, LHDs are unable to accrue for activity paid through an activity-based methodology where this exceeds the targets set in the service agreement.

126. In 2024/2025 NNSWLHD received funding equivalent to 0.7% growth for activity exclusive of TVH.

127. There are limited levers available to LHDs to control unplanned activity. By the end of the 2024/2025 financial year, it is estimated by the NNSWLHD that 55% of the projected deficit of approximately $70 million will be attributable to activity that had been provided that has not been funded at State Efficient Price, due to year on year over target activity provision due to demand growth. The remainder of the deficit is assessed as:

    a. $2.6 million due to small site funding gap (funding model under review), and $3.9 million related to structural costs above the State Efficient Price for TVH,

    b. $25.4 million efficiency gap which will require alternative service delivery arrangements to address, including continued general efficiency improvements. This is after a further $40 million in efficiencies is intended to be delivered in 2024/25.

128. To date key quality and safety performance indicators have not been impacted by the efficiency improvement program, although this position may change over the next two years. For example, from 1 July 2024 the NNSWLHD has stopped unbudgeted planned surgery theatre lists which is likely to impact on overdue planned surgery waiting lists. Alternative strategies have been put in place to mitigate the impact. The Quality and Safety of the care that is delivered will not be compromised.

(iii) Opportunities

129. A broadened scope of hospitals funded under the NSW Small Rural Hospitals Funding Methodology could reduce systemic inequity by incorporating both ABF (variable) plus fixed funding components.

130. A funding model which promotes greater collaboration between public health, primary care and residential aged care facilities is more likely to improve patient experience and outcomes by reducing fragmentation and enabling sharing of information and resources. An integrated and outcomes-based funding model that supports care in the community would assist the development of innovative models of care delivered where patients need it most.

131. A funding model that includes a focus on outcomes (rather than only inputs) linked to KPIs around equity of access would assist to support bespoke service delivery models that target resources to those most in need.

132. Enhanced integrated clinical service planning across the Commonwealth and State systems, for future service need, supported by an integrated, contemporary, funding approach would create an opportunity for all health service providers to collaborate around the right care being delivered in the right place, at the right time, by the right person, with the right information. A funding model which is integrated across the state and planned holistically will create efficiencies and improve equity of access.

G. WORKFORCE

(i) The NNSWLHD workforce

133. NNSWLHD has over 2800 full-time staff, over 2200 part-time and 712 casual staff, who combine with approximately 410 agency staff to deliver healthcare across the NNSWLHD.

134. The permanent staff base is comprised of:

Pay Period Ending 18-Aug-2024		
Medical	Full Time	429
	Part Time	62
active quinquennial appointments, these staff do not have full or part time status, they are contractors	Visiting Medical Officer	340
	Visiting Dental Officer	2
Nursing	Full Time	995
	Part Time	1426
Allied Health	Full Time	344
	Part Time	256
Other Prof. & Para Professionals & Support Staff	Full Time	87
	Part Time	51
Scientific & Technical Clinical Support Staff	Full Time	62
	Part Time	41
Oral Health Practitioners & Support Workers	Full Time	43
	Part Time	15
Corporate Services & Hospital Support	Full Time	603
	Part Time	315
Hotel Services	Full Time	207
	Part Time	108
Maintenance & Trades	Full Time	39
	Part Time	1
Other Staff	Full Time	4
	Part Time	1

135. NNSWLHD has experienced growth in FTE since 2019. This growth includes post flood support in 2023 and the service / facility expansion associated with 2024 TVH development.

136. The budgeted FTE as at the last pay period in financial year 2024 was 5,133 FTE. As of 3 July 2024, there are 452 open requisitions totalling 600FTE undergoing recruitment. This is 11% of the budgeted workforce.

137. Of all recruitment in NNSWLHD, 63% (379 FTE) is attributed to three facilities / services:

    a. TVH 24%

    b. LBH 20%

    c. Mental Health Services 19%.

138. In 2024, NNSWLHD had a higher rate of nursing and midwifery per 100,000 people (912.8) than the state average.

139. NNSWLHD's workforce is aging with its Allied Health and Nursing having the highest median age in 2024.

140. There are several factors which create challenges for working in rural areas regardless of the role performed:

    a. High cost of housing: the cost of housing and rents in some rural areas are high compared to average salaries. This is particularly evident in areas impacted by weather events – housing supply is reduced; and beach towns – where affordability is the predominant factor.

    b. Isolation from peers and professional colleagues. this limits the opportunity for staff to form professional networks and can limit personal supervision opportunities.

    c. Reduced opportunity for career pathways: there is a perception that career development may be limited when working in a rural setting. For example, due to the scale of operations, there may be limited opportunity to act in higher positions or specialise.

(ii) LHD wide workforce initiatives

141. The NSW Health's **Rural Health Workforce Incentive Scheme** (**RHWIS**) is a scheme provided to regional and rural areas which provides recruitment and retention incentives to attract and retain workers.

142. The RHWIS has been utilised to attract and retain health workers to NNSWLHD. There are currently just over 2,000 staff incentivised under the RHWIS across a broad range of occupations. This represents a relatively high use of RHWIS compared to other LHDs.

143. Utilising the RHWIS to attract new employees to hard-to-fill critical positions has enabled facilities to maintain services. This also contributes to improving staff wellbeing by ensuring adequate staffing levels in crucial areas.

144. NNNSWLHD has a marketing campaign that provides a background to the career opportunities and lifestyle on the North Coast. This campaign - 'You Care We Care' was launched November 2023 and is a strategy for staff recruitment.

145. Developed in collaboration with an external local agency, it draws on research and insights from existing staff who had relocated from other locations, and long-term staff, to gain insight into what motivates and matters to employees.

146. The 'You care We care' campaign is widely used, including on jobs boards, job advertisements, careers and training pages on the NNSWLHD website, social media – LinkedIn, Facebook, Instagram, electronic direct mail, expo related material and resources, and orientation. It also supports the ongoing general recruitment campaigns, along with more specific targeted campaigns such as the TVH campaign, GradStart campaign and the Junior Medical Officer (**JMO**) campaign.

(iii) Medical Workforce

147. Medical workforce in general is in short supply across Australia. That shortage worsened during the COVID pandemic period, with restrictions on the inflow of doctors to Australia and post floods where there was a reduction in all workforce professions. The supply problem is exacerbated by a deficit in the number of medical school graduates versus available intern positions. When there are insufficient interns in an annual intake, that progresses to an insufficiency in workforce in each subsequent post-graduate year. NNSWLHD has had several

years of insufficient junior doctor recruitment, increasing the locum JMO requirements.

148. A shortage of medical staff has led to a reliance on locums. NNSWLHD has high relative use of locums compared to the LHD rural/regional average. For example, as at 17 June 2024, NNSWLHD had 81.45 FTE vacancies for JMOs and Career Medical Officers. As these are critical roles, the vacancies are currently being filled by 77.45 FTE locums.

149. Engaging locum medical officers must be done in accordance with the Policy Directive *Employment and Management of Locum Medical Officers by NSW Public Health Organisations* (PD2018_019), and they must be remunerated in accordance with Policy Directive: *Remuneration Rates for non-specialist medical staff – short term/casual (locum)* (PD2012_046). In accordance with this policy directive, the standard special short-term remuneration rates for a locum filling a JMO role is in the range of $100 per hour to $145 per hour. In contrast, a Resident Medical Officer is remunerated in the range of $44.93 per hour to $60.77 per hour. The JMO Registrar is remunerated in the range of $55.98 per hour to $70.20 per hour. Whilst comparing remuneration packages for medical officers is more complex than an hourly comparison, the above demonstrates that there is a significant difference in hourly rates of pay.

150. NNSWLHD has the dual disadvantage of distance from Sydney, and proximity to the Queensland border. Many doctors prefer metropolitan work and non-work amenities, and without any standard remuneration advantage to working in rural and regional areas, there is competitive disadvantage when trying to attract senior doctors from Sydney.

151. Proximity to Queensland provides another opportunity to recruit, but the disparity in Award conditions for junior doctors and salaried specialists between the states means that NSW cannot compete effectively. Locum staff and some visiting medical officers can be sourced from Queensland. This was covered in more detail in NNSWLHD's submission to the Inquiry.

<u>Site specific challenges and opportunities</u>

a. Grafton:

   i. has a Regional Training Hub (Commonwealth funded) – assists in attracting junior doctors interested in long term rural careers.

ii. has challenges employing International Medical Graduate (**IMG**) specialists when college or the Australian Health Practitioner Regulation Agency require multiple supervisors for an interim period as some departments do not have sufficient supervisory capacity. These issues contribute to systemic locum use to ensure award conditions for rosters are met.

iii. has a strong relationship with University of Wollongong.

b. Lismore:

i. has a Regional Training Hub (Commonwealth funded).

ii. has Rural Preferential Pathway medical students, who have expressed an interest in rural medical careers.

iii. Lismore has strong relationships with the University of Sydney, University of Wollongong and University of Western Sydney in regard to rural medical school placements.

iv. has strong relationships with Sydney hospital networks which supply registrar level doctors, and some more junior doctors on rotation.

c. Tweed:

i. is a MM1 classification so is not rural and therefore does not benefit from a Regional Training Hub.

ii. various training programs have been developed in partnership with the medical schools of Bond and Griffith University, embedded in a long-term clinical placement, academic and research agreement;

iii. through Sydney based hospital networks, registrars and some junior doctors can be secured;

iv. the ED has a long-term program attracting Senior Resident Medical Officers from the United Kingdom (UK), principally driven by the continuous good experience and supervision provided, and word of mouth to their colleagues overseas.

d. Murwillumbah:

i. Is a MM1 classification so is not rural and therefore does not benefit from a Regional Training Hub.

ii. Health students were withdrawn by NSW Universities when the rurality classification (and associated Commonwealth funding) was withdrawn in 2021.

Specific initiatives implemented for Medical Workforce

152. Opportunities to enhance NNSWLHD's medical workforce attractiveness and options include online events to attract junior doctors to annual recruitments, and engagement in programs including the John Flynn Prevocational Doctor Program, Advanced Skills Training for GP Trainees and GPs, the Rural Generalist Single Employer Program, IMG observership programs, and the Workplace-Based Assessment program.

153. NNSWLHD coordinates a large portfolio of accommodation to ensure that suitable accommodation is available for junior doctors on rotation.

(iv) Nursing and Midwifery Workforce

154. The NNSWLHD nursing and midwifery team includes a diverse range of roles such as Registered Nurses, Registered Midwives, Enrolled Nurses, and Assistants in Nursing/Midwifery. This team encompasses various classifications, including Clinical Nurse/Midwife Consultants, Nurse/Midwifery Managers, Nursing/Midwifery Unit Managers.

155. Overall, there is a total FTE of 2,656 and a headcount of 3,630, which also includes casual staff and those provided through agencies. Of the permanent employees, 59% work part-time, while the remainder are employed full-time. The proportion of full-time staff has increased due to the overseas recruitment efforts, where candidates were employed full-time as part of their visa sponsorship.

156. There are noticeable differences in pay rates for nursing and midwifery staff between New South Wales and Queensland. This trend is also apparent in the Gradstart program, where candidates who live in south Queensland, often apply to both Queensland and NSW programs and may withdraw from NSW if they secure a position with Queensland Health.

157. With the overall Australian and international shortage of nursing staff, there has been a reliance on agency staff. The cost of agency staff is more expensive than

a permanent employee, due to: accommodation for the length of the contract, car rental if the accommodation is more than 45 minutes away from the facility, and travel to and from the contract location.

158. Prior to financial year 2022, NNSWLHD did not have a high use of nursing agency staff.

159. As a response to the devastating floods experienced in Northern NSW in February and March 2022, the Ministry of Heath negotiated a one-year emergency commercial agreement with a single agency for the provision of nursing agency staff.

160. The model negotiated was a contingent worker type agreement where NNSWLHD would pay the agency, who would then pay the nurses. This was a different engagement model than had previously been used. The traditional model required the LHD to pay the agency staff through payroll, whilst also paying a separate recruiting fee to an agency.

161. This emergency arrangement that was put in place was relatively expensive as can be seen by the expenditure data.

162. By the end of 2022, NNSWLHD had taken steps to attempt a transition to a more traditional arrangement, whereby the agency staff would be paid through payroll and a separate agency fee would be paid.

163. By June 2023, NNSWLHD had implemented a panel arrangement with a number of providers in which, in combination with changes in utilisation patterns has seen a significant decrease in expenditure on agency staff.

164. The panel arrangement negotiated by NNSWLHD will soon be replaced by a new Whole-of-Health Nursing Agency Panel arrangement that was negotiated by Ministry of Health and HealthShare NSW, and is expected to commence in September 2024. This is expected to result in lower agency costs.

165. For the last two financial years, NNSWLHD agency nursing expenditure was $94.067 million (FY 2022/2023) and $40.922 million (FY2023/2024). These figures reflect agency nurse expenditure through NNSWLHD payroll and payments made to the agency and its nursing staff. The above figures do not include additional costs associated with accommodation and travel, which were $15.473 million and $9.639 million for the FY2022/2023 and FY2023/24 respectively.

Specific Initiatives implemented for Nursing and Midwifery Workforce

166. Extensive Labour Market Testing during 2022 and 2023 identified a shortage of suitable domestic candidates for Registered Nurse vacancies. The district NNSWLHD Nursing and Midwifery team identified an opportunity to recruit overseas trained nurses through visa sponsorship.

167. There is an opportunity for continued recruitment of skilled overseas health care workers into NNSWLHD, into roles where there are no suitable domestic candidates. This may be achieved through an overseas candidate applying independently against an advertised vacancy; or a candidate may be referred via a Recruitment Agency outside of a specific recruitment episode. In all cases the local market is tested, and the position identified as unable to be filled, and the suitability of the candidate must be assessed.

168. An incentives package inclusive of visa application costs, relocation expenses and accommodation support was developed to attract suitable candidates.

169. In 2023 NNSWLHD undertook to complete all visa processing activity on behalf of candidates and manage the end-to-end process, to ensure timely submission of applications and full visibility of progress.

170. The nurses have predominantly come from the UK. As of 10 July 2024 the outcomes from this targeted overseas campaign were:

    a. Total candidates progressed to Visa: 133;

    b. Candidates who have commenced employment as at 8 July 2024: 105;

    c. Candidates with confirmed future commencement dates: 16;

    d. Candidates with Visa applications still in progress: 12.

171. Among incentives offered by NNSWLHD to nurses recruited from overseas is 12 weeks' supplied accommodation. Residential leasing was one of the approaches to housing provision preferred because it is more comfortable for staff and typically more cost effective for the NNSWLHD than commercial stays.

172. To proactively manage and encourage the nursing and midwifery workforce pipeline, there has been an increase in transition to practice numbers over the past five years and expanded capacity for student nursing placements.

173. NNSWLHD has significantly increased its engagement of Graduate RNs as follows:

	2018	2019	2020	2021	2022	2023	2024	2025
NNSWLHD Graduate RN	63	85	85	92	165	147	208	203

174. NNSWLHD has increased its nursing student placement capacity by 53 places in 2024, bringing the total available places to 242.

(v) Mental Health and Alcohol and Other Drugs Services

175. MHAoD has a headcount of over 900. This includes medical, nursing, allied health, and support staff.

176. All of the challenges and opportunities outlined above equally apply to MHAoD services. Of note is the acute shortage of Psychiatrists (also a national shortage) For example: on 6 September 2024, NNSWLHD had 7.4 FTE Consultant Psychiatrist positions vacant.

177. Most JMOs are employed by South East Sydney Illawarra Psychiatry Training Network and rotated to NNSWLHD.

178. MHAoD have implemented the following recruitment initiatives:

a. Bulk recruitment for Consultant Psychiatrists is open throughout the year to allow potential applicants to apply for positions at any time;

b. JMO ad hoc recruitment is undertaken to assist with backfill of rotational vacancies and will be incentivised under the RHWIS from February 2025.

c. Transition to Specialty Practice Program – offering 12 months in Mental Health to any Registered Nurses interested in working in a mental health setting who have no previous experience – supported by study days and mentorship.

d. Graduate Endorsed Enrolled Nurse (**EEN**) program – developed and planned for implementation in 2025. This is a 12 month program with fortnightly study days and confirmation of permanency on completion of the program. MHAoD have not previously taken graduate EENs.

e. Graduate Registered Nurse (**RN**) Program Graduate Certificate – Southern Cross University offer credits for a Graduate Certificate in Mental Health.

f. MHAoD have doubled the number of nursing student placements to encourage greater exposure to MHAoD services and encourage them to return as graduate nurses.

g. Liaison with academic and Aboriginal community partners to promote and attract staff. For example, there has been an increase of Djirruwang Trainee positions with two new Aboriginal workforce positions commencing in 2025.

(vi) Other Staff

179. Allied Health includes a range of disciplines that comprise social work, occupational therapy, physiotherapy, speech pathology, dietetics, podiatry, radiation therapy, sonography and radiography; amongst others. The greatest recruitment challenge is in rural and regional areas such as Grafton, Casino and Kyogle.

180. NNSWLHD has experienced difficulties recruiting oral health staff, and particularly dentists, including in regional and rural areas such as Casino and Grafton. For example, the Casino dental position was recently recruited to after it had been vacant for 3 years despite numerous previous recruitment attempts.

181. NNSWLHD often needs to use premium labour to ensure oral health services can be delivered in the context of national public oral health workforce shortages.

182. There are a range of non-clinical staff engaged at NNSWHLHD. This includes staff engaged in corporate professions and engineering trades.

183. Recruitment and retention across both professional and trade roles is challenging due to award-based pay commonly being below the pay rates available in the broader market. NNSWLHD is currently considering the development of entry level positions for professional graduates in partnership with local universities, and apprenticeship options for Trade roles.

(vii) NNSWLHD Culture

184. Whilst there are many and varied recruitment initiatives underway, I have ensured that leaders within NNSWLHD are equally focused on retaining our current workforce. Ensuring a positive work environment where staff wellbeing is paramount is a high priority for the ELT.

H. CONCLUSION

185. There are many challenges that, like other health systems in Australia and internationally, NNSWLHD must address in order for this organisation to continue to provide excellent health care now and into the future.

186. Fortunately, there are also many initiatives underway to do this. For example, State-based and local programs and initiatives that support contemporary place based / ambulatory and virtual models of care, population and community health and wellbeing programs, and initiatives to better support improved workforce recruitment and retention.

187. At the heart of these initiatives is the intent to improve the quality of care and the coordination (also referred to as integration) of care within and between teams and across healthcare settings. Integrated care is considered essential to address the quintuple aim of better health, better care, better value, improved equity, and enhanced staff wellbeing at a micro (patient), meso (organisational) and macro (population) level.

188. Valentijin [1] developed the rainbow model of integrated care. This widely referenced research describes six integration dimensions that should be considered when looking at a truly integrated system.

189. Whilst service delivery programs can ensure integration at a clinical, professional, and organisational level, what is often difficult to influence is systemic, functional, and normative integration. In my experience it is these later three areas that when addressed materially improve indicators within the quintuple aim.

190. To deliver integrated, sustainable, high-quality services now and into the future will require the State and Commonwealth to have:

    a. funding arrangements which are patient rather than place based (system integration);

    b. systems that are functionally integrated – financing, technology, service and workforce planning and policy setting; and

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[1] *Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care,* Pim P. Valentijn, MSc, Researcher, Sanneke M. Schepman, MSc, Researcher, Wilfrid Opheij, PhD, Senior Partner, and Marc A. Bruijnzeels, PhD, Director

c. normative alignment: healthcare organisations / participants have common goals, values, aligned behaviours and attitudes.

191. If these three dimensions are not addressed state and locally based contemporary models of care will not deliver their potential.

Signed:

Tracey Maisey

Chief Executive

9 September 2024

Witnessed:

Name: ELIZABETH BLAKE

Position: MANAGER, CE OFFICE

9 September 2024