Special Commission of Inquiry into Healthcare Funding

Statement of Tracey McCosker PSM

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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 Hunter New England Local Health District (**HNELHD**, also known as HNE Health), a role I have held since April 2023. I am currently also a Non-Executive Director of the Hunter Medical Research Institute (**HMRI**), a Board member of NSW Regional Health Partners, and a non-executive Director of Hunter New England and Central Coast Primary Health Network (**the PHN**). Prior to holding this role, I was the Chief Executive of NSW Health Pathology for over ten years. A copy of my curriculum vita is exhibited to this statement (**MOH.0010.0536.001**).

4. As Chief Executive of HNELHD, I lead a team of more than 18,000 staff and volunteers working across more than 100 facilities. HNELHD provides a range of public health services to almost one million people across the Hunter, New England and Lower Mid-North Coast regions.

B. GEOGRAPHY AND POPULATION

5. HNELHD is the only Local Health District (**LHD**) with a major metropolitan centre, several large regional centres, and many smaller rural and remote communities, across 131,785 square kilometres. A map of the geographic area HNELHD services and the locations of HNELHD's facilities is exhibited to this statement (**MOH.0010.0592.0001**).

6. HNELHD spans 25 local government areas and borders Queensland, the Mid North Coast LHD, Western NSW LHD, Central Coast LHD (**CCLHD**) and Nepean Blue Mountains LHD.

7. The traditional custodians from the land on which HNELHD operates includes Kamilaroi, Gomilaroi, Geawegal, Bahtabah, Thungutti, Awabakal, Aniawan, Biripi, Worimi, Nganyaywana, Wonnarua, Banbai, Ngoorabul, Bundjalung, Yallaroi and Darkinung.

8. The HNELHD population is approximately 950,298 people, with 9.1% of people identifying as Aboriginal or Torres Strait Islander. Of the population, 18% are over 70 years; 15% were born overseas; and 5% speak a language other than English.

C. HEALTH SERVICES

9. HNELHD operates over 100 different facilities including the following hospitals as well as over 60 community health services, 7 inpatient mental health facilities and 1 residential aged care service.

(i) Hospital facilities

10. An overview of the services offered at each of HNELHD's facilities is exhibited to this statement (**MOH.0010.0652.0001**).

11. Inpatient mental health facilities are located in the above facilities as follows:
    a. Short-term acute at Armidale, Tamworth, Taree, Maitland and Newcastle;
    b. Residential rehabilitation and recovery at Taree and Newcastle;
    c. Older people unit at Newcastle;
    d. Low support, high support, neuropsychiatry, and medium secure at Morisset;
    e. Psychiatric Emergency Care Centre – Newcastle;
    f. Psychiatric Intensive Care – Newcastle; and
    g. Child and Adolescent mental health inpatient service – Newcastle.

12. The 8 bed Psychiatric Intensive Care and 22 bed Newcastle Mental Health Unit are located on the Calvary Mater Newcastle campus.

13. HNELHD also has an agreement with the Calvary Mater Newcastle Affiliated Health Organisation (**AHO**) whereby HNELHD invests in Calvary Mater Newcastle through a subsidy to administer essential public health services through a purchaser-provider model, mirroring the collaboration between the Ministry of Health (**MOH**) and LHDs. In the 2023-24 budget, approximately $164.7M (an increase of $8.6m from the previous year) in funding was provided to Calvary Mater Newcastle. Calvary Mater Newcastle is the principal referral hospital for medical oncology, radiation oncology, haematology, toxicology, and specialist palliative care services. It forms the central hub of HNELHD's cancer network with responsibility for the whole district.

(ii) Community health services

14. HNELHD operates more than 40 community health services. Community health services may include community nursing, diabetes education, occupational therapy, podiatry, sexual health, renal, palliative care, women's health, as well as child and family health services to name a few.

(iii) Current Capital Works

15. HNELHD's current major capital works are:

    a. **The John Hunter Hospital and Innovation Precinct** – the redevelopment of the John Hunter Hospital and John Hunter Children's Hospital. Works began in October 2022 and are expected to be completed in 2026. The redevelopment includes the construction of a new Emergency Department (**ED**), doubling the capacity of the Intensive Care Unit and providing capacity for future expansion, with 22 operating theatres and 9 interventional suites, delivering five procedure rooms for endoscopy and minor procedures, and providing a purpose-built flexible education space with co-located clinical services. Also included is the new $15 million adolescent mental health unit.

    b. **Residential Eating Disorders Treatment Centre** – construction of a 12-bed centre at Charlestown is underway and will provide specialist support to people with severe eating disorders. It is due to be completed in late 2024. It will be the first publicly funded statewide service in NSW.

    c. Redevelopment of **Cessnock**, **Glen Innes**, **Gunnedah**, **Moree** and **Muswellbrook Hospitals.** The $138 million Cessnock Hospital redevelopment and $50 million Glen Innes projects are in the design phase, with concept designs

for both released in mid-2024. Main works are underway for the $53 million Gunnedah Hospital project. The Moree Hospital redevelopment has received additional funding of $25 million, taking the total investment to $105 million. The majority of the Moree Hospital design phase is complete, with the final scope to be finalised once a contractor is secured. The $45 million Muswellbrook Hospital Stage 3 project is on track and due to award the tender for the main works contractor.

d. **Lower Mid North Coast Health Service Project** – Manning Hospital Redevelopment – Stage 1 is complete and delivered enhanced cancer care services, renal dialysis services, medical imaging services, a hospital car park reconfiguration, increased consultation spaces and a refurbished hospital main entrance. In the 2024/25 Budget, the NSW Government announced an additional $80 million for the $100 million stage 2 Manning Hospital redevelopment, which has been combined with health services for the Forster Tuncurry region as the Lower Mid North Coast Health Service project, now totalling $180 million. HNELHD is now undertaking further services planning for the revised scope and budget.

e. **Maitland Mental Health Rehabilitation Facility** – development of a mental health facility at the Maitland Hospital campus was announced in October 2023 and community feedback is currently being sought regarding the concept designs. Many of the existing mental health services currently delivered at Morisset Hospital will transition to the new facility, which is due to be completed in early 2027.

f. **Tamworth Mental Health Unit** – development of a new mental health unit, with funding delivered by the Statewide Mental Health Infrastructure Program, is underway. The facility will include four additional adolescent inpatient beds, a 20-bed adult area and a five-bed adult high acuity zone as well as an eight bed older persons' pod. Construction of the unit is currently underway and is due to be completed in 2025.

g. **Maitland Mental Health Community Health Centre** – the development of a new community health facility to be located on the new Maitland Hospital campus is now complete. The design for the new $22 million development is now complete.

h. **Rural Clinician Accommodation Projects** – As a response to the shortage of clinician accommodation in regional towns and as a post-COVID stimulus

opportunity, HNELHD secured $20 million from the Department of Regional NSW to install 44 high-quality, sustainable relocatable residential units across 12 regional sites in partnership with NSW Public Works Advisory. Over the past six months, 350 staff have been accommodate. As a result of the new accommodation, agency staff are extending their stays, clinical services have improved with better medical coverage, there has been increased staff availability and reduced reliance on offsite accommodations, resulting in lower costs and enhanced service provision.

D. RESTRUCTURE OF CLINICAL OPERATIONS

16. In May 2024, HNELHD announced a restructure of its clinical operations into three core streams: acute hospitals; rural and regional health services; and integrated care services, networks and partnerships. It came into effect on 1 July 2024. A copy of the organisation structure is exhibited to this statement (**MOH.0010.0638.0001**).

17. The restructure established the position of Executive Director of Operations for the entire District, replacing the previous model which had two executive positions separately managing the Northern and Southern areas of the LHD. As a large LHD with a variety of facilities, one of the purposes of the restructure was to increase collaboration, improve access to care, incorporate community health services more effectively, and improve the patient experience through consistency and integration. This change helps us address workforce challenges and drive greater innovation in care delivery including by expanding our virtual care capabilities. Previously, larger rural referral hospitals managed smaller hospitals, creating a separation between different service types. The new structure ensures smaller facilities gain dedicated representation at a senior level and any changes to service delivery or models of care are considered at a whole-of-district level.

18. For similar reasons to the above, another key change from the restructure has been the addition of two general managers who sit on the clinical operations leadership team:

    a. The General Manager of Rural and Regional Health Services is responsible for all district and community hospitals, as well as MPSs throughout HNELHD.

    b. The General Manager of Integrated Care, Networks and Partnerships looks after all community health services, virtual care and external partnerships. The role also has oversight of district-wide services including oral health, drug and alcohol, networks and streams, as well as violence, abuse and neglect.

E. COMMUNITY CONSULTATION

(i) Local Health Committees (LHCs)

19. LHCs operate to provide leadership in the local community to ensure health services meet local health needs and ensure the promotion and enhancement of the health of the community. LHCs work with the local Health Service Manager and key community partners to represent the local community. LHCs play an important role in ensuring ongoing conversations are had regarding health service provision in local communities. This includes proposed changes to services, including explaining why the changes are being made and how HNELHD plans to maintain service availability to the area notwithstanding the changes being proposed.

20. A recent focus of HNELHD has been to re-invigorate the LHCs since their engagement reduced during the COVID-19 pandemic. Through significant consultation with existing LHCs and community stakeholders, the Strengthening Local Health Committees report was produced, which includes more than 70 recommendations to improve sustainability, governance, resourcing and community connection. The report and its recommendations were endorsed in late August 2024. There are currently 18 LHCs operating across the District and we continue to support them to engage proactively with their local health services. We will also work closely with them as we implement the recommendations from the report. It is expected that many of the recommendations will be implemented by early to mid 2025. A copy of the Strengthening Local Health Committees across HNELHD Report is exhibited to this statement (**MOH.0010.00594.0001**)

(ii) Changes to service provision

21. Our smaller facilities in regional and rural communities attract significant community interest when changes to service provision are proposed. These discussions often attract local political and media interest, sometimes resulting in delays to the modification of HNELHD's service provision.

<u>Wee Waa</u>

22. A recent example of HNELHD reducing the services of a facility is Wee Waa Health Service. This Service is a small 18-bed Peer Group D1 Community Hospital with a 3-bed ED. Similar to many hospitals across HNELHD, it has faced significant challenges in securing staff. Despite extensive efforts to recruit nurses, HNELHD announced on 20 April 2023 that from 8 May 2023, services at the facility would be temporarily reduced,

with the ED transitioning from a 24/7 operation, to one that operates from 8.00am until 5.30pm, 7 days a week. Outside of these times, emergency presentations are redirected to Narrabri Hospital. Those presenting to Wee Waa who required admission would also be redirected to Narrabri or another hospital within HNELHD. A copy of the media alert is exhibited to this statement (**MOH.0010.0593.0001**).

23. Significant community concern arose out of the decision to reduce operations at Wee Waa Health Service despite the context that the facility continues to have very low activity, averaging 2.6 presentations per day, the majority of which can be managed with nurse-led care. At the request of the Minister for Health, HNELHD established a working group that included local members of Parliament and community representatives to ensure staff felt supported and could continue to provide care. The working group last met on 1 February 2024.

24. To support local health services, a collaborative care program commenced in Wee Waa in May 2024. This is a place-based planning initiative aimed at developing community-led solutions to primary care and community health challenges. The program is led by the Rural Doctors Network and includes representatives from HNELHD, the PHN and other health organisations in the area.

Wallsend Aged Care Facility

25. Wallsend Aged Care Facility (**WACF**) previously housed 99 residents; however, occupancy has steadily declined over recent years. Since 2020, no new applications had been received, which is attributed to the facility not meeting consumer expectations of a modern, home-like environment.

26. Following an audit in late 2023, the Aged Care Quality and Safety Commission advised that WACF did not meet all the aged care quality standards. On 15 January 2024, a non-compliance notice was issued, however it was emphasised that there were no immediate risks to the safety, health, and well-being of the residents at WACF. In response to the non-compliance notice, the facility engaged an external consultant to develop a comprehensive Plan to Remedy, and the Commission subsequently reaccredited the facility until July 2025. However, the age of the facility means the building does not meet contemporary aged care standards and community expectations.

27. The decision in early 2024 to close the facility was made because the facility did not meet contemporary standards, and could no longer provide an appropriate, home-like environment for residents. Prior to the decision to close the facility in early 2024, it

housed 34 residents, 15-16 of which were National Disability Insurance Scheme (**NDIS**) recipients.

28. The decision to close the facility was also in line with the NSW Government decision to divest aged care facilities, which follows broader state and national agreements that aged care services are the responsibility of the Federal Government.

29. Despite there being broad acceptance that the facility was no longer appropriate to provide aged care services, there was significant resistance from the residents and their families as well as the local Member of Parliament, to keep the facility open, resulting in media and political advocacy. Our District consulted extensively with residents, their families and carers, staff, relevant unions and the NSW MOH about the decision. We developed comprehensive engagement and transition plans to help inform staff, residents, families and other stakeholders of the decision, including opportunities for discussion and consultation where appropriate.

30. A dedicated transition team has been working closely with residents, their families and support persons, as well as other providers, to identify appropriate, alternate accommodation options, and help residents transition to services that can better suit their needs. Almost all residents have now transitioned to their new homes, with only two NDIS residents remaining in the facility, both of whom have secured new accommodation and have transition dates scheduled in the coming weeks. The feedback from residents and their families has been positive and they are happy with the new accommodation arrangements.

F. COLLABORATIONS AND PARTNERSHIPS

(iv) Hunter New England and Central Coast PHN

31. HNELHD works closely with the PHN services alongside CCLHD. Both myself and Scott McLachlan, Chief Executive of CCLHD, are non-executive Directors of the PHN, enhancing HNELHD and CCLHD's ability to collaborate with the PHN.

<u>Diabetes Alliance Program Plus – Introduction of a medibus</u>

32. HNELHD collaborates with the PHN on several initiatives, such as the Diabetes Alliance Program Plus (**DAP+**). The DAP+ aims to improve health outcomes and care experiences for patients with diabetes with their general practice. Originally a collaboration between HNELHD and the PHN, the program expanded in 2023 with the

addition of HMRI and the University of Newcastle, thanks to a philanthropic gift from the Colonial Foundation to develop a medibus model of care. The DAP+ medibus will be available both as a structured clinic and a drop-in service, partnering with local healthcare facilities and community-based events to seamlessly integrate its services into the existing healthcare infrastructure.

33. Diabetes is a critical issue in HNELHD, with 1 in 8 of the population estimated to have diabetes, one-third of which remain undiagnosed. Consequences of unmanaged diabetes progression include higher rates of heart attacks, amputations, strokes, kidney failure, blindness and even premature death. The economic toll is also significant, costing Australia $17.6 billion annually.

34. The medibus allows HNELHD to take specialist multidisciplinary teams consisting of endocrinologists, diabetes nurses, dietitians, Aboriginal Health Workers and podiatrists to rural and remote towns that may not have access to these services locally. These clinical teams also provide training to local providers, and directly care for and educate patients. The model of care can easily be customised for rapid application to other chronic and complex health conditions, which could have a big impact for rural and remote communities.

35. This partnership enables cohesive decision-making and coordinated efforts in advocacy, implementation, funding, and evaluation. As a result, the program has effectively responded to community needs, earning the respect and trust of both providers and participants. This integrated approach ensures a unified strategy that aligns resources and expertise, leading to successful outcomes and widespread recognition.

Hospital Health Pathways (HHP)

36. The HNELHD HHP was developed as a result of collaboration between the PHN, HNELHD, and CCLHD. It is an online clinical pathway that provides quick, easy access to best practice clinical guidance and support for clinicians. HHP includes referral information, discharge criteria and patient support services. Whilst originally the intended audience was Junior Medical Officers (**JMO**s) as well as our transient workforce (locums), HHP is now used by clinicians across our workforce. HNELHD was the first site outside of Canterbury, New Zealand, to implement the program.

37. Outcomes from implementation surveys carried out in 2018 (pre-HHP), 2021 and 2023 indicated that 60% of JMOs would be very/extremely likely to use HHPs daily. This is

also reflected in the usage measured through individual page views to the HHP site, which has increased from 89,892 in 2021, to 187,658 in 2023.

(ii) Aboriginal Medical Services

38. We have recently established Aboriginal Medical Services (**AMS**) Partnership meetings, with the first taking place in Tamworth in early August 2024. This included representation from Tamworth AMS, Armajun, Pius X Aboriginal Corporation, Awabakal, and the Walhallow Aboriginal Corporation, to establish effective ways of working together and providing better support and health care coordination for Aboriginal people. These meetings will occur quarterly moving forward.

(iii) Hunter Medical Research Institute

39. HMRI was established as a strategic partnership between the University of Newcastle, HNELH D and the community, with members of each of these partners represented on the HRMI Board. Through its physical links with HNELHD and John Hunter Hospital, HMRI plays a vital role in integrating excellent clinical care and innovation with world-leading basic, translational and population health research from the University of Newcastle. It provides the central "hub" for research funding, strategy and infrastructure across the region and enables researchers, healthcare professionals, policy makers, industry, and the community to work together to address health issues, locally and across the world.

(iv) University partnerships

<u>Joint Medical Program</u>

40. The Joint Medical Program is delivered by the University of Newcastle and the University of New England, in partnership with HNELHD and the CCLHD. The partnership gives medical students the opportunity to study and train at a metropolitan or rural campus, with both locations offering an identical Joint Medical Program curriculum. An intended goal of the Joint Medical Program is to retain doctors in the rural and regional areas of HNELHD.

<u>Rural midwifery pathway</u>

41. Delivered through Charles Darwin University in partnership with 7 participating hospitals across HNELHD, the rural midwifery pathway offers registered nurses a postgraduate diploma of midwifery with a specific rural focus. There is good retention, as approximately

75% of all graduates remain working in rural and regional facilities, with many transitioning to education or leadership positions.

G. SUSTAINABILITY

42. HNELHD is implementing its 'Together Towards Zero' sustainability strategy, establishing itself as Australia's leader in healthcare sustainability. Understanding that unhealthy environments contribute significantly to human disease and death, and that the health industry itself is a major carbon emitter, we are taking significant steps toward clean, green healthcare. Achievements in the past three years include the world's largest solar installation on a hospital, a 31% reduction in CO2 emissions, a 20% reduction in waste going to landfill, a 29% reduction in water usage, and $3.4 million in recurrent savings redirected into operations. Our fleet is transitioning to electric vehicles and e-bikes, and we are encouraging sustainable travel practices among staff. These efforts are part of our broader commitment to ensuring a healthier legacy for future generations.

(i) Gloves off program

43. The 'Gloves Off' project is a research initiative at John Hunter Hospital aimed at improving hand hygiene and reducing the unnecessary use of non-sterile gloves. Misuse of these gloves is common in clinical settings, leading to poorer hand hygiene practices and significant waste. Across HNELHD, about 28.3 million non-sterile gloves are used annually, contributing 97 tonnes of waste to landfills with a carbon footprint equivalent to driving around Australia 175 times. The project's goals include enhancing hand hygiene compliance, increasing healthcare staff's confidence in risk assessment, reducing glove overuse, and developing a quality improvement package for broader implementation.

(ii) Outfits to fit-outs

44. HNELHD staff can contribute to the new $835 million John Hunter Health and Innovation Precinct by recycling their old uniforms into green ceramic tiles. So far, five collection drives for old uniforms have been completed, with plans to expand these collections to other district facilities in the coming months.

(iii) Tamworth Hospital going green

45. Tamworth Hospital has developed an award-winning initiative repurposing 50,000 litres of excess water produced from renal dialysis, once considered wastewater, to flush toilets. This $15,000 investment saves 2.5 million litres of clean water annually and will

be expanded to 10 more renal units across the District. This project highlights the environmental impact of haemodialysis, a process with significant energy, water, and plastic waste demands.

46. HNELHD provides approximately 41,000 haemodialysis treatments each year, with a carbon footprint equivalent to driving 9.7 million kilometres and generating 25 tonnes of recyclable plastic annually. HNELHD has partnered with a local recycler to explore ways to divert this plastic waste from landfills. This is in addition to the hospital's solar panel installation and energy-saving lights.

H. FUNDING

47. The funding type of each of HNELHD's facilities is set out in the table exhibited at paragraph 10 above. Two thirds of HNELHD's budget comes from Activity Based Funding (**ABF**).

(i) Funding challenges

48. A downside of the ABF model is that it does not account for the service differences between rural and metropolitan areas, placing a strain on rural facilities. Sufficient allowances are not made for additional costs for transportation, accommodation, and delivery costs to rural and remote facilities. The higher fixed costs associated with the running of HNELHD's smaller facilities is offset to an extent, by the efficient running of John Hunter Hospital, which operates below the State Efficient Price. The costs of running smaller facilities in rural and regional locations is also increasing, primarily due to the need to engage locum staff to continue operating the facilities as well as the increasing costs of goods and services more generally.

49. Similarly, the national weighted activity unit (**NWAU**) system does not accurately account for the higher costs of providing services in rural regions. This is particularly relevant as premium labour costs, goods and services continue to escalate. For example, the costs associated with patient transfers. Due to the size of HNELHD, coupled with the smaller facilities requiring increased support from larger centres, HNELHD is moving patients across a large geography. Compared to smaller or metro LHDs, this takes more time and comes at significantly greater cost, which is unfunded as part of the NWAU. As a result, facilities in metropolitan areas, particularly John Hunter Hospital, subsidise and underwrite the more expensive rural health services across the District.

50. The ABF model also does not prioritise moving to newer models of care that focus on keeping people out of the acute hospital setting, for example the new Residential Aged Care In-Reach service combines virtual and in-person services and ensures that the risk of unnecessary transfer to hospital is significantly reduced for aged care residents. The ABF model does not account for the delivery of new services because the funding is calculated based on retrospective activity. Any new services would require a new funding application and the ABF model does not provide for additional funds to invest in new services.

(ii) John Hunter Children's Hospital – funding challenges

51. The John Hunter Children's Hospital (**JHCH**) faces additional challenges in funding compared to other children's hospitals in the State. Established in 1995, JHCH is based in Newcastle, and serves as both a tertiary referral hospital and the primary outreach service for northern NSW.

52. Unlike the Sydney Children's Hospitals Network (**SCHN**), which is funded separately as a dedicated tertiary/quaternary children's service with a substantial budget, JHCH competes for funding within the HNELHD budget. This limits JHCH's ability to enhance its services and infrastructure. JHCH lacks a dedicated building and operates across five major care facilities, leading to staff dislocation and inefficiencies.

53. JHCH provides non-funded outreach specialist paediatric services throughout northern NSW, stretching already limited resources. We deliver these services unfunded because families outside of metropolitan centres would not have access to them otherwise.

(iii) Financial Performance

54. It is an ongoing challenge for HNELHD to meet its financial KPIs under the Service Agreement. We had a budget shortfall in FY2023/2024, driven by increasing demand and length of stay, having to pay for premium labour, as well as the substantial costs associated with transporting patients between facilities to receive the most appropriate care.

55. This also has an impact on our performance KPIs. For example, since 2021, we have been unable to meet our transfer of care target of offloading 90% of patients from the ambulance within 30 minutes. People are waiting longer than they should for surgery, and some hospital-acquired conditions have increased, which in turn contributes to a longer length of stay.

56. HNELHD has several efficiency improvement plans in place to actively monitor progress towards financial recovery targets. Achieving the savings, without having a further impact on performance KPIs is a fine balance that we regularly monitor.

57. We also have a number of strategies in place to improve performance targets, including a focus on faster discharging to increase bed capacity, better utilisation of theatre capacity collectively across our major hospitals, and increased utilisation of our virtual hospital services.

58. Strategies include:

    a. 24/7 patient flow unit – In August 2023, HNELHD transitioned its patient flow unit to a 24-hour service, seven days a week. Having a 24/7 dedicated unit has helped reduce the after-hours workload on our staff, creating better flow, and benefit our patients through a consistent 24/7 streamlined transfer of care process.

    b. virtualKIDS Urgent Care Service is a 24/7, nurse-led virtual care service delivered by SCHN and HNELHD. The service offers remote clinical advice, education, and support to NSW families, to help avoid unnecessary visits to hospitals where appropriate.

    c. Ensuring surgical services are optimised. There are several actions underway, including having a single point of contact, after-hours nurse unit manager for operating theatres, review of access and activity levels of endoscopy suites, and considering theatre capacity within a 30-minute drive of John Hunter Hospital. These recommendations and establishing a procedural network are being considered and communicated to the broader network.

I. WORKFORCE

(i) Make-up of the medical workforce

59. Securing a consistent, reliable medical workforce in regional areas is a challenge faced by many LHDs, including ours. Due to a shortage of medical staff choosing to live and work locally in the regions, as well as a decline in the number of GPs working in rural areas, we have an increasing reliance on the use of locums to ensure we have medical coverage for our hospitals, There is also increasing costs to secure locums, who can command high fees due the lack of supply and increasing competition between hospitals to secure their services.

60. For the last three financial years, locum medical expenditure was $34.287 million (FY2021/2022), $49.958 million (FY2022/2023), and $60.887 million (FY2023/2024). These figures reflect salary and wage costs only and do not include additional costs associated with accommodation, travel, and agency commissions.

61. The proportion of medical locums and agency staff against the overall medical workforce costs (both salary and wages, and VMO) across HNELHD in FY 2022/2023 was 7.7% increasing to 12% in FY2023/2024.

(ii) Overview of challenges

62. A key challenge for HNELHD is attracting and retaining skilled healthcare workers. HNELHD has faced workforce shortages since the COVID-19 pandemic. The challenges are as a result of:

a. changing work preferences, for example an increased preference to work part-time;

b. NSW Awards, including remuneration and working conditions, are less competitive than other states such as Queensland;

c. staff preferencing metropolitan locations; and

d. delays with recruiting staff from overseas during the pandemic.

63. As a result of workforce shortages, HNELHD:

a. is heavily reliant on high-cost agency staff and locums, which has a significant impact on our financial sustainability as mentioned above.

b. has not met its benchmark against many of the performance targets aligned to NSW Health's strategic priorities. For example in FY 2023/2024 72.7% of patients were transferred from the ambulance to the ED in less than 30 minutes (target 90%). The last time HNELHD met its transfer of care target was in FY 2019/2020. Over this period there has been a 23.8% increase in ambulance arrivals and a 40.7% increase in triage category 1 presentations, both placing additional load on our already busy EDs.

c. faces difficulty with maintaining medical coverage, particularly in regional and rural areas which is also attributable to the large geographic size of HNELHD. On any

given day a number of our rural and regional facilities have business continuity plans (**BCPs**) in place due to gaps in the medical or nursing workforce. The BCP outlines strategies to manage and mitigate the impact of this, including alternative care arrangements, resource reallocation, communication protocols and patient transfer processes. This ensures patient care and safety, even when the usual medical and nursing workforce is unavailable. In July 2024, 14 of our rural and regional hospitals had multiple BCPs in place over the course of the month, due to a lack of medical, nursing, midwifery, and perioperative staffing. The impact of this resulted in reduced birthing services or transfer to larger facilities, cancellation of surgeries, and a reliance on virtual medical care for ED presentations.

64. Further challenges exist for HNELHD as a LHD that nears the Queensland border for the recruitment of staff, including:

a. administrative complexities in recruiting staff from Queensland, further compounding the staffing challenges, especially for those living near the border. Attracting suitable candidates from Queensland Health to work in HNELHD facilities is challenging due to the difference in pay structures and awards, with Queensland Health offering higher pay. Further, NSW-specific processes, like the Working with Children Check (**WWCC**) and Occupational Assessment Screening and Vaccination (**OASV**) onboarding, create further delays and complications. These requirements, combined with the need for evidence of previous service for salary assessment, can be time-consuming and discouraging for candidates, particularly when the end result is less competitive than what Queensland Health offers. The statewide agency panel for nursing, due to be introduced soon, is expected to streamline parts of the onboarding process, potentially making it easier for nurses to work in NSW.

b. The limitations in shared databases across NSW Health are not solely due to non-participation between states, but also involve the need to update and adopt policies across different LHDs. While systems like eCredential (medical system) were intended for statewide use, they are not effectively utilised, with HNELHD using its own system (**SCPRAC**) instead to suit our purposes for credentialling and onboarding. Similarly, while Recruitment and Onboarding (**ROB**) is used across NSW Health, access is limited to each respective LHD. Evo VMS, a digital platform used in the medical locum space shows potential for reducing duplication across LHDs. Further, Queensland Health offers significant rural and regional workforce incentives, which are more straightforward and financially attractive compared to

the NSW Health Rural Health Workforce Incentive Scheme (**RHWIS**). Queensland Health's incentives include substantial payments without repayment requirements, whereas NSW's scheme is more restrictive, leading to confusion and frustration among employees.

(iii) JMOs

65. HNELHD faces a significant deficit in JMOs across three distinct groups:

a. **Prevocational Post Graduate Year 1 (PGY1) and Year 2 (PGY2):** These JMOs are allocated through a statewide process managed by the NSW Health, Education and Training Institute (**HETI**). Historically, there has been a stable supply of these positions, however for the upcoming calendar year we have been informed of a potential shortfall due to a decrease in the number of individuals pursuing a medical career.

b. **Accredited registrars:** This group includes registrars in accredited training positions, which are allocated by medical colleges between metropolitan and regional and rural areas. Currently, there is a disproportionate number of training positions in metropolitan areas, leading to a trend where trainees establish roots in these regions and are less inclined to move to regional or rural locations.

c. **Senior Resident Medical Officers (SRMOs):** This group comprises unaccredited SRMOs, predominantly international medical graduates (**IMGs**), who lack formal relationships with medical colleges.

66. The shortage of JMOs in HNELHD is exacerbated by a lack of permanent senior staff to provide supervision and training, as well as challenges in retaining staff. Competing offers such as more attractive awards in other states, lucrative locum positions, and a preference for metropolitan work contribute to this issue.

67. HNELHD has implemented strategies to address our workforce shortages generally, and also specifically to improve HNELHD's attractiveness to JMOs. These initiatives have been implemented following extensive consultation conducted by Dr Paul Craven, Executive Director of Medical Services and Executive Director of Networks and Streams, who travelled to HNELHD's larger hospitals in 2023 to discuss with staff their understanding of the causes. Dr Craven also convened a one-day forum in December 2023 to address HNELHD's challenges with recruiting and retaining JMOs. I understand

Dr Craven has discussed some of the initiatives HNELHD has employed to improve JMO recruitment and retention in his statement.

Learn as you Earn AIN project

68. The Learn as You Earn Assistant in Nursing (**AIN**) program sees HNELHD partner with TAFE NSW and the University of Newcastle to provide undergraduate medical students with a work-integrated learning model. The program targets first and second-year Bachelor of Medical Science/ Doctor of Medicine (Joint Medical Program) students and offers them a pathway to recognition of prior learning as a Certificate III in Health Service Assistants (**AIN Acute**).

69. Students are required to attend three TAFE-led workshops and complete 80 hours of work-integrated learning at a HNELHD facility. After successful completion, participants are eligible to work in HNELHD as an AIN, while they continue their medical studies. This HNELHD initiative is the first of its kind in Australia and has the potential to be a very scalable model to address our nursing workforce challenges. Since its inception in late 2023, 24 students have completed the program, and have gone on to work in HNELHD facilities, as well as residential aged care facilities and NDIS organisations.

(iv) International Medical Graduates (IMGs)

70. HNELHD recruits a significant number of IMGs to address local workforce shortages. There are two main types of IMGs:

    a. **IMGs in early practice**: These are IMGs in their first, second, or third year of practice, who come to Australia without general registration. HNELHD employs them as PGY2s and SRMOs. This group constitutes the majority of our junior doctors and requires extensive supervision - more so than their Australian-graduated counterparts. The key authority for their assessment is the Australian Medical Council (**AMC**), which oversees workplace-based assessments and exams.

    b. **Specialist IMGs:** This group includes IMGs who already hold specialist qualifications from their home countries (for example, the UK). They are assessed by specialist colleges, with peer reviews typically required for validation. In rural networks, conducting these peer reviews is challenging due to the limited number of qualified specialists available to oversee them.

71. Since 2016, HNELHD has hosted triannual orientations for IMGs to integrate them into our medical workforce. Our orientation program focuses on cultural integration and professional expectations, helping IMGs transition smoothly into our system. We have also implemented a workplace-based assessment program, which boasts a 99% pass rate - significantly higher than the 15-30% pass rate of the AMC examination-only approach. This program has become a leading model in Australia, adopted by over 20 other centres.

72. The recruitment and onboarding process for IMGs is lengthy due to visa wait times and processing timeframes of the Australian Health Practitioner Regulation Agency and specialist colleges. Furthermore, IMGs require substantial supervision by senior staff, which is particularly challenging in our rural facilities with limited medical coverage.

73. To improve onboarding, HNELHD is launching a new initiative in December 2024, allowing IMGs in early practice to start their roles six weeks earlier than usual. This will enable them to shadow outgoing JMOs and become familiar with their new environment before officially starting in February 2025. This initiative aims to enhance their orientation and integration into their new roles.

(v) Medical Specialists

74. Attracting medical specialists to regional areas is increasingly challenging, leading to an increased reliance on locums and agency doctors. For example, 42% of Armidale Hospital's medical officer costs were paid to locums and agency medical staff in FY24. In particular, the inability to attract anaesthetists affects the delivery of obstetric, surgical and critical care services. Consequently, staffing challenges at our rural and regional facilities also have downstream impacts with our larger hospitals such as John Hunter Hospital and Tamworth Hospital having to provide support, creating further capacity and resourcing challenges.

75. Aside from Rural Referral Hospitals, such as Tamworth and Armidale, all other rural facilities heavily depend on General Practitioner (**GP**) Visiting Medical Officers (**VMOs**), positions which also face recruitment and retention challenges. The current Award and agreements do not incentivise GPs to work in rural facilities and many are not prepared to work for a fee-for-service payment. Many GPs are unwilling to work the caseloads that GPs might have previously worked, leading to more GPs being required to cover a community than has previously been the case. Additionally, it is difficult to attract and retain new GPs as they are not willing to work at facilities with onerous on-call rosters.

(vi) Specialist College Accreditation

76. I have line of sight over the processes of specialist college accreditation across HNELHD's facilities and participate in maintaining positive communication between HNELHD and the colleges. Prior to my commencement as Chief Executive, in 2020 Maitland Hospital lost its basic training accreditation from the Royal Australian College of Physicians (**RACP**) and has not yet obtained its accreditation back. On 30 November 2020, the RACP withdrew its accreditation of basic physician training for Maitland Hospital, due to concerns with supervision, training, teaching and workloads.

77. In response to the concerns raised by RACP, a comprehensive review took place, and the District is actioning changes in relation to staffing, rostering, leaderships, structure, interaction with management, teaching, training, and research. Maitland Hospital has now established a fifth medical team, as well as recruited a Clinical Director for the Department of Medicine. It has also recently established a new Emergency Short Stay Unit (**ESSU**), as well as utilising My Emergency Doctor to provide higher-level medical support and consultation to smaller networked hospitals, which was previously provided by clinicians working in the Maitland Hospital ED.

78. It has taken a large amount of Maitland Hospital's and HNELHD's resources to improve the facility and services following the withdrawal of accreditation because of the need to recruit further staff to fill the space the trainees would otherwise have filled.

79. Additional funding for supervision support would greatly benefit HNELHD. Integrating overseas specialists, particularly specialist IMGs, is challenging due to varying college standards and supervision requirements. These issues are more pronounced in rural areas, where a shortage of local specialists makes it difficult to meet supervision needs. Streamlining requirements and boosting support could ease these challenges and improve staffing across both urban and rural facilities.

(vii) Locum usage

80. As previously stated, locums are engaged to address employment vacancies and to ensure HNELHD facilities remain open. The use of locums to address vacancies in the medical and nursing and midwifery positions has a significant impact on HNELHD's budget. Facilities often find themselves bidding against each other to secure the same locum, and locums tend to wait until close to the required shift to confirm their attendance when rates are higher. I am aware of reports that agency staff also often withdraw from

their pre-booked contract at the last minute, only to re-negotiate for a higher rate. The impact of the increased reliance on locums is not only financial:

a. the quality of locums varies significantly, and many do not actively contribute to the culture of teaching and quality improvement.

b. continuity of care may be compromised as locums are usually engaged on a short-term basis (for example, a 12-hour shift).

c. there is an increase in permanent staff leaving their roles or taking leave without pay, to become locums and take advantage of the rates, which is up to three times more than their regular salary. For example, junior staff at John Hunter Hospital have been leaving their JMO positions to work as junior locums elsewhere in HNELHD, leaving John Hunter Hospital understaffed. This practice has now ceased to the extent that leave without pay is not endorsed for JMOs to work as locums within other HNELHD facilities.

d. disenchantment of permanent staff because their locum colleagues are earning triple the amount for the same work.

(viii) Nursing and Midwifery

81. Recruitment and retention of nursing and midwifery staff also presents significant challenges for HNELHD. Despite continuous recruitment efforts, vacancies have arisen over the past two years, exacerbated by increased clinical expectations due to a shortage of medical officers. Staff are often requested to work overtime and extended consecutive days, impacting on wellbeing. HNELHD has many strategies to attempt to address these workforce pressures, including advertising regular, ongoing expressions of interest across HNELHD and requests to the MOH for secondments. Centres such as Tamworth encourage flexible working practices, including rostering, part-time managers positions, and there is regular use of rural relief staff, agency staff and indirect staff through clinical networks for secondments.

82. HNELHD supports “grow your own” initiatives. For example, the Registered Nurse (**RN**) transition to midwifery practice program, which allows training RNs to provide some support to maternity services within clinical scope. Maternity services also host school-based trainees, and Assistant in Nursing/Assistant in Midwifery undergraduate pathways to midwifery. While these programs have great potential, it is noted that these are longer-term solutions, and do not address the immediate and urgent staffing situation.

83. HNELHD also utilises the available attraction and retention incentives, including the Rural Health Workforce Incentive Scheme (**RHWIS**). However, the incentive packages are limited by the classification of locations under the Commonwealth Modified Monash Model, with areas such as Tamworth being classified as a MM3 area and receiving a reduced incentive despite its critical shortage of midwives.

84. In instances where HNELHD cannot secure enough services, some facilities such as Wee Waa Hospital have reduced their hours of operation as set out above. Further, the lack of midwives is impacting maternity services in rural areas, with some of our facilities downgraded or unable to offer midwife-led services. Tamworth Hospital Birthing Suite is regularly required to reduce capacity from 20 to 12 beds in order to maintain a safe service. However, as the Level 4 rural referral facility for many smaller hospitals, this reduced capacity also reduces its ability to support smaller sites. Additionally, the shortage of midwives exacerbates the challenge of adequately staffing an obstetrics and gynaecology service, in the context of HNELHD also facing challenges recruiting and retaining GP anaesthetists and obstetricians.

85. Challenges recruiting appropriately qualified theatre nursing and support staff also impacts our ability to provide higher level obstetric care, as theatres cannot operate for caesarean section and post-birth procedures without these staff and supporting services. As a result, we are re-considering how HNELHD provides maternity services to rural and regional communities across our District and whether there is an opportunity to consolidate the various resources we have across different sites to ensure we can provide more sustainable maternity services.

86. Although virtual ED medical support, has been successful, there can be challenges with securing appropriately skilled nursing staff to support this model. For example, there must be two nurses rostered on, with advanced life support and triage skills. Ensuring these skills are present at all times in the ED can often come at the expense of the staffing levels in the inpatient units.

Implementation of Rural Nurse Practitioner (**NP**) workforce

87. NPs have played an important role in HNELHD for over 22 years. HNELHD currently has the most Nurse Practitioners and Transitional Nurse Practitioners in the state (104 positions), with more than half providing services in our rural and regional areas.

88. NPs in HNELHD practice in 24 different specialities including the ED, neonatal intensive care units, palliative care and mental health. NPs provide comprehensive and

specialised care, reducing the burden on other healthcare professionals and increasing efficiency.

89. HNELHD has established governance processes for the implementation of the NP workforce in various specialities, including through a comprehensive guide sheet which outlines the necessary steps for implementing NP roles. It starts with an expression of interest phase to determine local support for nurses to undertake post graduate qualifications. Services may also initiate a business case for the establishment of a NP role. It also includes extensive stakeholder engagement with local GPs and all relevant clinical staff to educate them about the role and address any concerns they may have. A local NP governance group is also established which includes GP or medical officer representation.

90. HNELHD has developed the 'Emergency Nurse Practitioner' (**ENP**) workforce model which aims to improve healthcare access and outcomes across HNELHD's rural and regional facilities. Following the recommendations of the *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales* Inquiry, HNELHD has increased its ENP workforce, growing from 8 in 2022 to 41 in 2024.

91. From a clinical perspective there have been no significant challenges experienced by our NPs, however those in our rural sectors have identified systemic barriers relating to working to full scope including the inability to provide referrals to specialty services as NPs are unable to access an individual Medicare provider number. NPs also cannot certify Centrelink, Isolated Patients Travel and Accommodation Assistance Scheme, and Comcare Certificate/documents or death.

(ix) Allied Health

92. Recruitment and retention of allied health staff is impacted by non-government organisations (**NGO**s) and the National Disability Insurance Scheme (**NDIS**) service providers offering higher pay often for less demanding work, resulting in the reduction or closure of allied health services in smaller towns. For example, the dedicated sexual assault service clinician (social work) position at Moree, while currently filled, has been regularly and chronically vacant in recent years. When this position is vacant, the service relies on other local clinical staff with appropriate training or will be on bypass to Tamworth for crisis responses. For longer-term counselling, the service has regularly been required to divert clients and victims to alternative providers – local NGOs, private providers or services in other locations.

93. The Muswellbrook Community Speech Pathology Service has been unable to recruit to a long-standing vacant speech pathologist position. This has forced the service to reduce its scope from an assessment and treatment service, to an assessment-only service, meaning clients are now unable to receive public treatment locally. The patients are now placed on an extensive treatment waiting list, and are generally referred to other services, both in the private/NGO sector or other public services, to receive treatment. The vacancies impact the broader health system by causing delays in patient discharge from hospitals, contributing to bed block issues in larger facilities, and hindering the timely provision of allied healthcare to other inpatients due to increased long-stay patients.

94. Our Allied Health Directorate manages a number of workforce programs to support Rural Allied Health clinicians and teams across the District. Two key programs include the Rural Generalist Program and Rural Reliever Program. The Rural Generalist program is targeted at early career professionals and is supernumerary for sites. It aims to give early career allied health professionals the experience of living and working in rural areas, whilst they develop the skills and experience to meet the needs of patients in rural areas.

95. The Rural Reliever program is a permanent level 3 position and was established to maintain the provision of Allied Health services during periods of staff absence in rural sites across the District. This includes staff taking leave for annual leave, professional development and other leave. Both have proven popular and successful at supporting allied health staffing in our regional areas.

96. We are also looking at how we might be able to translate other successful health-led models to support patient flow and discharge. For example, the transition team in place to facilitate the transfer of residents from Wallsend Aged Care Facility to their new accommodation could be a very effective model in other hospital settings. Allied Health clinicians are also increasingly used in EDs to provide primary and secondary care. This means appropriate presentations can be seen and treatment commenced faster, without the need to wait for medical assessment. This enables faster discharge from the EDs, reducing the waiting time for others who do require medical assessment.

J. PRIMARY CARE, AGED CARE, NDIS

97. There are shortfalls in services funded by the Commonwealth including primary healthcare, aged care and NDIS services across HNELHD. As a result, HNELHD is subsidising such services.

98. Additionally, because of the difficulty with obtaining an appointment with a community GP, an increased number of patients are presenting to our EDs with conditions treatable by a GP. The increased number of patients attending our EDs results in longer wait times, negative community perception of our services and a more stressful environment for staff and patients waiting for care.

99. Length of stay of aged care patients and NDIS patients in acute HNELHD beds is also increasing. As at 29 August, there were 44 NDIS and 83 aged care patients in our facilities who had exceeded their date of discharge. These are complex patients who often need complex community care. This has a major impact on the operations of a hospital and causes bed block in the ED and in turn impacts our KPI performance. It also impacts our budgets when providing this type of care to patients that should be receiving support and funding from Commonwealth programs, rather than state funded acute care. If there was a mechanism to charge back to the Commonwealth for these services being provided in an acute facility, this would free up more budget for providing true acute health services.

100. We are also seeing patients presenting for healthcare later, with complications or more advanced chronic disease, which could have been treated earlier and managed had they had access to a GP. Acute services are then put under pressure to manage conditions that would have been more appropriately managed in the community, had the patient had the right support available.

(i) Tomaree Medical Centre

101. Tomaree Medical Centre, located on the Tomaree Community Hospital campus and operated by HNELHD, provides GP services for semi-urgent, non-urgent and complex care, as well as chronic disease management and preventative healthcare for those in the Port Stephens area. The centre operates five days a week, excluding public holidays. It was established due to a lack of available primary care services in the Port Stephens region, and a need to divert less urgent patients from the ED.

102. Tomaree is classified as a Distribution Priority Area (**DPA**) which takes into account the demographics and socioeconomic status for patients living in a GP catchment area. A DPA is an area that has been assessed as not receiving adequate GP services for the needs of that population. This classification system is administered by the Federal Government.

(ii) Inverell Fast Track GP Clinic

103. The urgent care clinic is a bulk-billing service managed by HNELHD and co-located at Inverell Hospital. One of the primary reasons the urgent care clinic was established in 2013, was because of the reduction in GP availability in the area, putting more pressure on Inverell Hospital as lower acuity patients were presenting to the ED rather than local general practices for care.

(iii) Mobile imaging van for residential aged care facilities

104. HNELHD's imaging service has launched a mobile x-ray service for residential aged care facilities, operating five days a week. The mobile service covers 43 facilities and will provide general radiography support to aged care facilities that would otherwise be required to go to an ED. The service is Medicare-billed eliminating out-of-pocket costs for residents.

(iv) Bulahdelah multipurpose service proposal

105. Bulahdelah's 13-bed hospital closed in 2012 as the ED and inpatient beds were underutilised, and patients requiring a higher level of care were transferred to larger facilities within the HNELHD network. The facility was then transitioned into a community health service with a nurse-led clinic, allied health, and community health services.

106. The reduction in services coupled with the closure of nearby Cedar Wharf Lodge, a 57-bed nursing home run by Anglicare in 2022, has resulted in local community concern about the future of health services in the region. The Bulahdelah and District Health Action Group has put forward an application for a MPS of which HNELHD is supportive, however this is a decision of the Commonwealth Government.

K. HNELHD INITIATIVES AND INNOVATIONS

(i) Health Innovation Living Lab

107. The Health Innovation Living Lab is a $2.3 million partnership between HNELHD and the University of Newcastle that focuses on digital health, sustainability, medical technology, and operations. The Lab facilitates collaborative projects, including bio-fabrication services using 3D printing for surgery planning and virtual reality training through the University's Centre for Advanced Training Systems.

(ii) Mental Health First Responder (MHFR)

108. The MHFR is designed to assist police or ambulance emergency services first responders to triage cases where a person may be experiencing mental ill health, to avoid unnecessary transfer to hospital. The service delivers 24/7 virtual mental health triage on mobile devices. The MHFR is now available in 88 towns across the HNELHD regions with more than 1400 police and 750 paramedics trained in the virtual program. The program has several benefits for patients including reduced trauma, home-based support and more appropriate care. From a system perspective, it has resulted in reduced presentations to the ED, and efficient use of resources including keeping police and ambulance in the community. From 19 October 2022 to 30 June 2024, the program completed 310 MHFR triages, resulting in 43 (13.9%) recommendations for police and ambulance personnel to transport the person to an ED, but importantly provided 267 (86.1%) recommendations to divert from the ED to more appropriate care, meaning 267 community members avoided an unnecessary ED presentation.

(iii) Command Centre

109. HNELHD is in the process of exploring a digitally enabled command centre function. The command centre would combine existing, traditionally siloed services or departments such as transfers, bed management, transport, and patient access into one place, creating significant efficiencies including streamlining patient flow, reducing wait times and optimising the use of limited resources. The increased efficiencies would also positively impact healthcare professionals by reducing administrative burden.

(iv) Stroke helmet

110. In a world-first trial with NSW Ambulance, HNELHD is using cutting-edge technology to assess and triage stroke patients during their transfer to hospital. This new brain scanner, the MD100 helmet, allows for more patients to be imaged within the ‘golden hour’ post-stroke, without delaying routine pre-hospital procedures, with paramedics in the Hunter region able to consult directly with the neurology team at John Hunter Hospital, optimising care and outcomes for stroke patients.

(v) Mobile dental van

111. HNELHD has introduced a mobile dental van program to deliver dental care and education to rural and regional schools and communities. The program has served over 150 students, with 74% identifying as Aboriginal or Torres Strait Islander. For 36% of all students, this is their first dental visit. The program prioritises building trust and

collaboration with local communities and Aboriginal community-controlled health organisations to emphasise the importance of oral hygiene.

(vi) HNEKidshealth complex care coordination

112. HNELHD's complex care coordination service is designed to support children with medical complexities and their families – who account for over 30% of healthcare costs. This service unites representatives from various sectors and specialties, ensuring coordinated care for these children as they transition from acute care. In the six months following the service implementation, coordinated same-day appointments increased from 7% to 60%, substantially reducing travel requirements, school and work absenteeism, and associated costs for families; and of those enrolled in the service, there was an 80% reduction in ED presentations to John Hunter Children's Hospital.

L. STRATEGIES AND INITIATIVES TO ADDRESS HEALTH DISPARITIES BETWEEN ABORIGINAL AND NON-ABORIGINAL PEOPLE

113. In January 2024, HNELHD announced it would reorganise its Aboriginal Health Unit to better deliver its strategic priorities to close the gap. This follows the announcement in late 2023 that it would elevate the Director of Aboriginal Health position onto the executive leadership team. The approach of the Aboriginal Health Unit and its primary focus on health promotion meant that there were inconsistencies and fragmentation for Aboriginal patients engaging with HNELHD's services.

114. As a result, HNELHD has restructured the Aboriginal Health Unit into three streams:

b. cultural governance for clinical and community-based care to close the gap;

c. integrated care with oversight of the District's Aboriginal Health Workers and Practitioners; and

d. chronic care program.

115. The team is now focused on reviewing its strategic priorities against NSW Health's Aboriginal Health Plan 2024-34.

116. The HNELHD 2022-23 Closing the Gap Annual Report, highlighted several improvements in closing the gap outcomes, including those related to breastfeeding, following up on patients with chronic disease and acute mental health after their hospital discharge, and increasing the number of Aboriginal employees. The report also

highlighted areas for improvement to provide a more culturally capable and responsive health service for the Aboriginal community such as ED did not wait and leaving at their own risk and smoking during pregnancy. Also, the number of staff completing face-to-face 'Respecting the Difference' training had declined compared to the previous reporting period due to the mandate that all staff complete training.

117. Several strategies and initiatives are underway to address health disparities and improve Aboriginal health outcomes.

(i) Healthy Deadly Feet

118. The Healthy Deadly Feet program, launched in July 2019, targets the disproportionate rate of foot-related complications among Aboriginal people. Key aspects of the program include community outreach, inpatient foot assessments, cultural care navigation, and health promotion within the Aboriginal community. This initiative has led to a 150% increase in podiatry attendance for Aboriginal patients, hundreds of screenings, and a 68% rise in Aboriginal-based referrals. The program has contributed to reducing major amputations and decreasing the average length of hospital stays for diabetes-related foot issues in Tamworth Hospital. Patient feedback has been overwhelmingly positive.

(ii) Little Ears. Deadly Care

119. The "Little Ears. Deadly Care" program is an initiative at HNELHD, addressing the disproportionate impact of ear, nose and throat (**ENT**) issues for Aboriginal and Torres Strait Islander communities. On our ENT outpatient waitlist, 14% of people identify as Aboriginal and/or Torres Strait Islander, with this figure rising to 20% of children.

120. This audiology pathway provides eligible Aboriginal children with comprehensive assessments by a dedicated audiologist, followed by case conferences for precise surgical advice. So far, nearly 300 patients have benefited. Our multidisciplinary ENT service, including GPs, audiologists, respiratory specialists, nurses, and Aboriginal Health Practitioners, is committed to reducing wait times and improving access to care, especially in regional and rural areas.

(iii) Aboriginal engagement in infrastructure, planning, and sustainability

121. HNELHD's Infrastructure, Planning and Sustainability team is committed to "Designing with Country," ensuring Aboriginal cultural values are integrated into the health-built environment. By fostering meaningful relationships and shared decision-making with

Aboriginal communities, HNELHD aims to create culturally safe spaces where Aboriginal patients feel respected and supported. This approach addresses the significant disparities in health access and outcomes, emphasising the importance of culturally responsive facilities in improving Aboriginal health and wellbeing. This approach is especially important, with more than 30 per cent of Aboriginal patients avoiding health services due to cultural inappropriateness, and with Aboriginal patients being five times more likely to discharge themselves against medical advice than the rest of the population.

M. CONCLUSION

122. The delivery of sustainable healthcare services to rural and regional areas in NSW faces significant and ongoing challenges, particularly considering workforce shortages, high short-term labour costs, and the complexities associated with service provision across a diverse geography.

123. Despite these obstacles, our District remains committed to delivering high-quality and accessible health services through strategic partnerships and innovative models of care. As outlined in this statement, there are several initiatives already underway to build a sustainable workforce, limit our environmental impact, enhance our service delivery, and improve our performance against KPIs, using our available resources within the current funding framework.

124. However, to continue meeting the unique healthcare requirements of our regional, rural, and remote communities we need a funding model that's both responsive and adaptable and holds all contributors to the provision of health care accountable. I trust that the insights and evidence provided in this statement will assist the Special Commission of Inquiry in its deliberations and ultimately contribute to the development of a sustainable and equitable healthcare funding model for all of New South Wales.

Tracey McCosker	Witness:
13 September 2024	13 September 2024