Special Commission of Inquiry into Healthcare Funding

Statement of Associate Professor Martin Cohen

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Occupation:	Board Chair, Hunter New England 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. This statement also responds to matters raised in the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (MOH.0010.0541.0001).

A. INTRODUCTION

3. I am the Board Chair, Hunter New England Local Health District (**HNELHD**). I have also served previously as Deputy Commissioner of the NSW Mental Health Commission, and I am a qualified psychiatrist, working in private practice, and a Fellow of the Royal Australian and New Zealand College of Psychiatrists.
4. Prior to joining the HNELHD Board, I was the Executive Director of Hunter New England Mental Health Service and Director of Specialist Training. A copy of my curriculum vitae is exhibited (MOH.0010.0588.0001).

B. BOARD GOVERNANCE

5. HNELHD spans 25 Local Government Areas from Newcastle to the border of Queensland, making up 131,785 square kilometres and serves a population of nearly one million including 64,333 Aboriginal and Torres Strait Islander people and 169,846 overseas born residents. It employs over 18,000 staff and is supported by 1,600 volunteers. It is comprised of one tertiary referral hospital (John Hunter Hospital), four rural referral hospitals, 12 district hospitals and eight community hospitals. HNELHD operates over 60 community health services, seven inpatient mental health facilities and three residential aged care services.

6. Parts 2 and 3 of schedule 4A of the *Health Services Act* set out the constitution and procedure of Local Health District (**LHD**) Boards and s. 28 sets out the functions of LHDs.

7. The HNELHD Board is responsible for:

    a. Ensuring effective governance and risk management processes are in place to guarantee compliance with the NSW Public Sector Accountability Framework.

    b. Improving local patient outcomes and responding to issues that arise.

    c. Monitoring HNELHD performance against measures outlined in the Service Agreement.

    d. Delivering services and performance standards based on annual strategic and operating plans within an agreed budget. This forms the basis of our Service Agreement.

    e. Ensuring HNELHD provides services efficiently and accountably.

    f. Producing Annual Reports that are subject to State financial accountability and audit frameworks.

    g. Maintaining effective communication with local and State public health stakeholders.

8. As Board Chair I am appointed by and accountable to the Minister for Health. I am responsible for the effective functioning of the Board and for managing the performance of the Chief Executive, through an annual review process.

9. The Chief Executive, Ms Tracey McCosker, is accountable to the Board, in accordance with her annual performance agreement, in the exercise of her functions. She has a dual accountability to the Secretary, NSW Health.

Board and Committee Structure

10. The HNELHD Board has thirteen members with the mix of skills required by s. 28 of the Health Services Act. This includes expertise, knowledge and experience in Aboriginal health, held by Professor Peter O'Mara, Associate Professor, Indigenous Medical Education and Head of Discipline – Indigenous Health at the University of Newcastle.

11. Schedule 4A of the *Health Services Act* requires the Board to invite the following to Board meetings:

    a. The Chief Executive (or nominee);

    b. The Chair of the HNELHD Medical Staff Executive Council (**MSEC**), and

    c. At least one representative of the executive leadership team.

12. The Board meets monthly. Meetings are organised on a rotating basis, alternating between a virtual meeting, and meetings onsite at our hospitals or community services across HNELHD. Meetings are always attended by the Chief Executive or delegate, and members of the Executive, and by the Chair of the MSEC, Dr Mary Morgan. We have a strong and positive relationship with the Medical Staff Executive Council, and the contributions and advice from Dr Morgan is tabled as an agenda item for all face-to-face Board meetings.

13. The Chief Executive provides a report in advance of each Board meeting. The report outlines the activities of the Chief Executive as well as key risks, system changes, and progress reports on Board monitored activities. In addition, the CE reports directly on Work Health and Safety, and WorkCover notifications. The Board papers include detailed data and commentary addressing the key performance indicators (**KPIs**) set out in HNELHD's 2024/25 Service Agreement, which is exhibited (MOH.0010.0662.0001). The Board also reviews minutes and/or receives presentations from the Board Committees discussed below. The Board receives a presentation of a patient story at each onsite Board meeting, that focuses on staff performance, the patient journey, and orients the Board to local issues. In addition, thematically organised deep dives into key risks or strategic directions or performance are presented by the CE and are aligned to the key focus areas of the Executive Leadership Team. Finance and Healthcare Quality Committee KPIs are discussed with the Board by the Chair of the respective committees, and papers are reviewed, and key strategic and operational risks are discussed. Follow-up items will often be generated which are given a specific timeframe for reporting back to the Board. These priorities can be allocated either to the Chair of the respective committees to govern, or the CE, and are reported back to the Board. Once the Board is satisfied that the risk is adequately treated, then the matter may be passed back to the respective committee or closed.

14. The HNELHD By-Laws, exhibited (MOH.0010.0661.0001) are established in accordance with section 39 of the *Health Services Act 1997* and provide for the following sub-committees of the Board:

    a. Audit and Risk Committee;

    b. Finance and Performance Committee;

    c. Healthcare Quality Committee (**HCQC**);

    d. Community and Patient Partnership Committee;

    e. Medical Dental Appointments Advisory Committee;

    f. District Clinical Council;

    g. Aboriginal Health Committee; and

    h. Sustainability Committee.

15. The HNELHD By-Laws provide for management committees to provide advice to and consultation with the Chief Executive and the Board. Such committees operating within HNELHD include:

    a. Medical Staff Councils (**MSCs**), to enable clinicians to provide advice on medical matters;

    b. The MSEC is made up of representatives from the MSCs, which enables streamlined communication from the various MSCs to the Board;

    c. Hospital Clinical Councils which provide a structure for consultation with clinical staff and the General Manager in management decisions; and

    d. Medical and Dental Appointments Advisory Committee (**MDAAC**) including the Credentials (Clinical Privileges) Subcommittee.

16. Each Board sub-committee, other than Audit and Risk, is chaired by a Board member and usually includes at least one member of the LHD Executive or delegate. The Board appoints clinician representation in consultation with the MSEC or Clinical Council. The Audit and Risk Committee includes members independent of the LHD. A summary of each Board Committee and meeting frequencies is exhibited (MOH.0010.0666.0001).

Monitoring of Performance

KPIs

17. KPIs are set out in the Service Agreement entered into by HNELHD with the Secretary, NSW Health. For each KPI, there is established a series of measures by reference to which achievement of the KPI is measured. Typical KPIs include or relate to patient experience ratings, hospital acquired complications, Emergency Department wait times, elective surgery waitlist lengths, mental health admission, seclusion and follow up, and unplanned re-admissions. There are specific sustainability KPIs concerning activity and financial performance as well as KPIs linked to preventative and public health programs and innovation. Assessment of KPI performance is in accordance with the 2024-25 Service Agreement Improvement Measure Data Supplement, exhibited (MOH.0010.0663.0001).

18. The Board monitors all KPIs, with financial performance KPIs overseen by the Finance and Performance sub-committee, and KPIs concerning safety and quality in the delivery of health services overseen by the Health Care Quality sub-committee. The Audit and Risk Management Committee, receives all data, and reviews these data against performance. The Chairs of the Health Care Quality Committee (**HCQC**) and Finance and Performance Committee are observers on the Audit and Risk Management committee. Both the HCQC and Finance and Performance committees of the Board present to the Board on performance against these KPIs at Board meetings.

Board consumer, community and stakeholder engagement

Governance structure

19. The Community and Patient Partnership Committee of the Board is chaired by Dr Kirsten Molloy. Her professional experience brings an in-depth knowledge of governance processes, strategy development, enterprise risk, stakeholder engagement, creation of constructive cultures and working collaboratively. Dr Molloy is President of the Hunter's Equal Futures Project, a not-for-profit focussed on equity and diversity, and founded Verity Leadership, to support leaders who want to transform their organisations, cultures and leadership. This leadership structure ensures that we have the community voice contributing directly and consistently into our governance systems so we can develop strategies for productive and sustainable community engagement.

20. The Board has ensured resourcing is in place to support all our facilities to be able to engage in meaningful community engagement. Through the development of a strategy that considers the need for training and support, and the right skill mix, the District has developed the *Strengthening Local Health Committees Report*, exhibited (MOH.0010.0664.0001). This report was developed following extensive community and staff consultation and has recently been endorsed by the Board. The report identified that resourcing, in the form of administrative funding to ensure the sustainability and stability of this governance mechanism, was required and was endorsed by the Board.

21. There are currently 18 Local Health Committees (**LHCs**), which is a health service managed, community group for local community engagement and health advocacy. This model provides the LHD with advice and input into the functioning and development of local health services. Traditionally LHCs function well when there is a pressing issue for the community or the community is particularly engaged in the provision of health services. The Board requires stable structures that are reliable and present consistently over time to provide advice into the governance chain over time. The Board has required the CEO and Executive to develop this governance mechanism. Dr Molloy has led this process with executive allocated by the CE. The requirement is for the consistent provision of advice through to the Board in a meaningful and collaborative manner. The Board has endorsed the strategy and all recommendations in the *Strengthening Local Health Committees Report*.

Aboriginal and Torres Strait Islander engagement

22. At Board level we have strong integration with Aboriginal Community Controlled Health Organisations (**ACCHOs**). The Aboriginal Health Committee, chaired by Board member Peter O'Mara, connects with consumers and community, and reports directly to the Board to support the work of HNELHD in initiatives to "close the gap" in Aboriginal and Torres Strait Islander health outcomes. Ms McCosker recently met with the Chief Executive Officer of Aboriginal Medical Service (**AMS**) and has regular communication with Aboriginal and Torres Strait Islander medical corporations to further the LHD's engagement with Aboriginal consumers.

23. The Committee takes oversight of our Aboriginal Health strategies which are looking to put 'rubber to the road' in terms of closing the gap, by focusing on health outcomes in a more direct way. This process is early in development, but the operational processes for this are reported through the Committee and then on to the Board.

24. The Board is kept informed of HNELHD's collaborative planning with ACCHOs and Aboriginal healthcare partners, in making sure that the design of HNELHD services is validated by Aboriginal communities we are working with. There are strong examples of this in mental health, vaccination, and child and adolescence services. The cooperation between AMSs and our services is strong and is becoming more tuned in to delivering the quality and type of service that is culturally appropriate. I believe HNELHD's levels of engagement with our Aboriginal community has strengthened over time but needs to continue to evolve with the needs of those communities and how they would like us to position and shape our services to the community's needs.

Community consultation

25. There is extensive consultation with the community and consumers in relation to service closures or changes and all major capital projects.

26. If HNELHD is funded for a service, it is unlikely to be closed unless the service is either not fit for purpose, no longer required or can be provided by another resource. Where a need for service change is identified, HNELHD would go through a process of working with Ministry of Health (**MOH**) and take advice regarding transformation into another service that is better suited for the community. The process for closing and changing services can take years. The process of restructuring services is one where the CE will make a presentation to the Board, extensive consultation will already have occurred with the MoH, and the Board will review the strategy, associated risks - clinical, financial and reputational, and take advice and deliberate on the advice. The Board will then either express support for the strategy or request more information. This is an iterative process that can occur over many months or years, prior to service change or closure being endorsed by the Board.

27. Detailed clinical and operational consultation underpins any major change process. An example of such a process occurred with Morisset Hospital, a mental health unit which housed long term residents. For example, the Pathways to Community Living Initiative, which involved moving people with complex and chronic mental health problems from Morisset Hospital into the community via a controlled, programmed and extensive relocation program. HNELHD and the Board worked with the Mental Health Executive Director, received briefings, and governed the process that was led by the MoH. The process involved extensive community consultation and engagement with clinicians, consumers and families. It also involved working closely with not-for-profit organisations

and, community groups to achieve the goal of supporting people with chronic and complex mental health problems to live safely within our community.

28. Consultation includes more than direct consultation with an affected group and may include liaising with media and community advocacy groups, and clinicians who are passionate about certain service subtypes, about medium and long term benefits of changes in service delivery. When you talk about health services that are near and dear to small and large communities, there will always be a level of anxiety in the community and resistance to change. It is incumbent on the LHD to meet and discuss with concerned community members and clinician groups to help people understand the reasons behind service changes.

29. In a recent example of this, there was a change to pathology services in Moree and Narrabri that were viewed as problematic by the community and staff in those areas. The Board received a detailed briefing on the reason for this change and how it is governed and why the benefits of the change outweighed any negatives. We were satisfied that not only this was the right thing to do, but that the communities, clinicians and our patients would not be put at risk. The briefings were detailed and provided by the CE to the Board. The Board was satisfied that advice to the Board from the CE provided reassurance the process was well governed, aligned with a strategic need, did not compromise quality or safety, and was in the best interests of the local communities affected.

30. Service change is evolution and ensures our services will continue to progress and provide the right kind of service at the right place and right price. Services need to change, grow, and develop based on changing demographics and local need, the availability of resources including human resources and financial resources, and the evolution of new technology and efficiencies.

31. Capital projects are usually detailed and long-term involving multiple stakeholders over years to move the project through to gateway (a system that provides project assurance through independent peer reviews at key decision points (Gates) in a project), and then review by Treasury. Facilitating the evolution of these projects from inception to hand over to clinical staff is an enormous enterprise and involves extensive input from community, our clinical teams and operations teams. These projects are managed in accordance with Government Policy and includes extensive auditing, reporting and consultation, including with experts across clinical and non-clinical epidemiology to provide assurance that the proposed capital investment meets the future health needs

of the local community. The outcomes are directly tailored to the current and future health needs of the populations in the specific areas of our LHD.

32. Board briefings occur on a regular basis when major infrastructure funding is sought. In addition, the Board is regularly briefed on the process of developing the epidemiological models that underpin future community needs, and advice is readily provided by the CE to the Board regarding the process of prioritisation by government for the potential capital funding. The Board is briefed on the consultation process with community, consumer groups, local government, the Ministry of Health and other key stakeholders. Progress updates are provided when capital works begin, and throughout the capital works process. The Board is also informed of key risks as they evolve and ongoing consultations that occur with clinicians and management staff about change management processes, and ultimately new models of care agreed-upon, their efficiencies and potential benefits for our community. Detailed briefing also occurs on the transition process and potential risks and treatments in the transition to the new hospital or facility are discussed with the Board. The Board receives advice through the HCQC, Finance and Performance Committee, and District Clinical Council as well as the Medical Staff Executive Council on risks that may relate to their relevant scopes of governance. The triangulation of metrics and reports to the Board from Board Committees, such as District Clinical Council assists the Board to understand more fully from multiple perspectives each of the KPIs as it impacts on finance, governance, and our clinicians.

33. The District Clinical Council provides the Board and the Chief Executive with advice on clinical matters affecting the organisation. This committee is led by Prof Penelope Paliadelis, who is a registered nurse with extensive knowledge in entry-to-practice education and clinical leadership in both metropolitan and rural facilities, including previously for HNELHD.

Consumer engagement

34. The HNELHD has a particular focus on embedding the voice of the consumer in our governance systems. One of the challenges for all LHDs is creating models that allow for the consistency of consumer and community members voices into our system. Unfortunately, there is significant community energy and consternation when a problem arises, and community and consumers are activated to engage with the District, but when there is not a problem, it is often difficult to keep the same level of engagement. The COVID pandemic had significant impacts in terms of the connection between us as individuals on the Board in our roles serving the community, and between our hospitals

and community. Consumers are individuals who utilise our services, and community are gatherings of individuals who may have had at some stage to use our service but have a vested interest in terms of ensuring the stability of service and its quality regarding meeting the needs of the community. The HCCQC is chaired by Elizabeth Nichol who has strong executive and non-executive experience, with expertise across leadership, culture change, governance, and risk management. Ms Nichol has a particular interest in creating a safety and wellbeing excellence culture, resulting in quality outcomes for patients and enhanced safety, mental health and wellbeing for employees. This committee is responsible for governing and monitoring the safety and quality of our clinical services as required by the National Safety and Quality Health Service Standards.

35. Ms McCosker and the Executive have been working hard to reinvigorate consumer engagement, which is a critical piece of Ms McCosker's accountability to the Board. The voice of the consumer in our governance systems is important to us, ensuring that we are properly connected with consumers and providing the services that consumers expect of us. This process is monitored through the HCQC , monitoring national standard 2, and through the *Strengthening Local Health Committee* report and strategy. The CE and executive sponsors, who attend the Board Meetings, Community and Patient Partnership Committee and HCQC are held accountable by the Board for the implementation and monitoring of Board endorsed strategies, such as that described above, and the National Safety and Quality Health Service Standards.

University and research centre engagement

36. There is strong collaboration and cooperation between HNELHD, the University of Newcastle (**UoN**) and their medical research centres. The Chief Executive, Ms McCosker, and the Executive Director Research and Innovation, Prof Levi, sit on the Board of the Hunter Medical Research Institute (**HMRI**), which I previously sat on. We also have direct integration at Board Level with a number of universities and two Board members who sit or have sat on University Councils, Elizabeth Nicholl (currently UoN Council) and Peter O'Mara (previously UoN Council). This integration of HNELHD Executive and Board members facilitates HNELHD's strategy and long term vision for strengthening innovation through our clinical trials program.

37. This integration with UoN also assists in medical training programs, with HNELHD operating programs which incentivise UoN students to take internships at HNELHD through medical student placement with high degrees of supervision, rotations of medical

students, and a focus on onboarding and engaging medical students. There are a number of specific programs that make sure we stay in touch with those students and try to make sure that our local medical students stay local. For example, we have a psychiatry program called Hunter New England Training in Psychiatry offering a comprehensive range of training experiences for trainees in regional locations more than favourably with metropolitan based training programs. The success of this program is seen in HNELHD's very high rate of converting local interns into psychiatry training. UoN students know these programs exist as our staff specialists lecture at the universities, and many of us hold conjoint academic positions with the university, myself included, and integration occurs at every level from the Board down. By way of example of the recognition this program has received the following endorsement from the Royal Australian and New Zealand College of Psychiatrists "The Hunter New England Psychiatry Training Network is a very well-run program offering a comprehensive range of training experiences for trainees in a fully regional location that compares more than favourably with metropolitan-based training programs" (RANZCP Accreditation Report, 2019).

Other service providers

38. Formal engagement with the Primary Health Network (**PHN**) occurs mainly at Chief Executive rather than Board level, with Ms McCosker sitting on the PHN Board. The Board is, however, kept informed of work being done on developing new models of care between HNELHD and the PHN and improving flow of care services. A number of Board members are also engaged with the PHN through existing relationships and there is an informal degree of communication, networking and cooperation with the PHN at Board level. Personally I have met the CEO on several occasions over many years, and have existing relationships through previous work with the PHN.

C. CHALLENGES FACED BY HNELHD

Funding

39. HNELHD is a geographically and demographically broad and complex district with both large hospitals funded according to an activity based funding (**ABF**) model and a number of smaller facilities that are block funded. ABF is not an appropriate model for smaller currently block funded hospitals, but the cost base for these smaller hospitals has increased over time, without a corresponding increase in funding. There is a resulting level of cross subsidisation, which the HNELHD Executive is actively working with MOH

on. The Board is regularly briefed on coding, compliance with activity based funding reporting requirements, have a detailed understanding through executive briefings with regard to the work of our coders, and indeed the clinical challenges of ensuring diagnoses are accurately recorded by our clinical staff. As Chair, I review the Service Agreement, which is also reviewed by the Board, and Board committees are briefed in a detailed manner regarding performance, funding, safety and quality.

40. There are always going to be challenges regarding funding of healthcare, which would consume the entire state budget if all needs were to be met, so we must ensure at the Board level that we are governing and ensuring that HNELHD's level of quality and safety is as stable as possible over time. The Board's focus is on striking a balance between HNELHD working towards improvements and doing so within the available allocated budget.

Workforce

41. HNELHD experiences workforce challenges, partly because other states pay more for the same work and are able to attract employees from NSW. HNELHD reaches the State's north west, bordering part of Queensland, and these areas are impacted by this issue the most. This also occurs where certain specialties are far behind the private sector in terms of pay and staff specialist contracts are not competitive, for example in psychiatry. When you start to see some loss of workforce, then there is an increasing reliance on the locum workforce which impacts on morale, culture and stability of services in health.

42. HNELHD has multiple adaptions to meet workforce challenges and stabilise these issues. For example, the after-hour psychiatry roster covers the entire district to support rural and regional areas, and there is a telehealth model, Virtual Mental Health Emergency Care, that supports rural and regional Emergency Departments to get direct access to psychiatry services. This service is run by HNELHD and provides service to 30 EDs, including to the Mid North Coast and Northern NSW LHDs. We have networks and streams throughout the district that bring together our capabilities across multiple specialties including, but not exclusive to, respiratory, cardiac, and mental health and drug and alcohol services. There is a sharing of skills and capability, and to some extent workforce, across the district in this network model to make sure that we maintain stability in terms of services and quality. Those networks and streams foster quality of connection for our clinicians which means our people support each other, particularly when we lose our workforce due to illness or resignation across the district.

43. From a Board level, we see programs such as the Single Employer Model, the Rural Health Workforce Incentives Scheme and the District's rural clinician accommodation strategy as effective in attracting future workforce. The accommodation strategy has been particularly effective in Tamworth, where the Board has received on-the-ground verification from staff that it has attracted them to work in in our rural and regional areas. We recently held a Board meeting in Muswellbrook and discussed the ability for nursing staff to work in multiple hospitals depending on availability and the need for accommodation to support this. HNELHD delivered 44 accommodation units to 12 sites over an 18-month period – four of these are located at Muswellbrook and eight at Tamworth. In the first six months, 350 staff were accommodated overall, with many agency staff electing to lengthen their stay.

44. Primary healthcare is changing and the availability of General Practitioners (**GP**) in rural and regional areas is becoming more limited. For example, HNELHD is significantly challenged with the input of GP Anaesthetists and Obstetricians into our systems and our services. GPs with extra training are not as available as they once were, and they do not work as much as they used to, creating extra pressures on our system, particularly in rural and regional settings. The challenges we are experiencing with primary care produce flow on effects into our facilities, as people presenting to our Emergency Departments in the rural and regional context often cannot readily access primary care. As a result, in some areas HNELHD in collaboration with PHN has established a bulk billing GP service to reduce pressure on EDs and provide an alternative to patients seeking non-urgent care.

Aged care pressures

45. The aged care system has been under significant pressures as it adapts to evolving standards and quality and safety requirements in accordance with Federal Government guidelines. This has led to a significant issue, both operationally and from a governance perspective, with the number of patients who are in acute beds across HNELHD but should instead be in a residential aged care facility. This has significant implications for the availability and utilisation of beds but also for funding and allocation of resources across HNELHD.

46. Aged care patients more frequently present to Emergency Departments, usually by ambulance, when aged care facilities are not functioning optimally. The threshold for people being moved into our acute care system has lowered, with more elderly patients

with complex health problems admitted to hospital. This leads to a further challenge when residential aged care facilities are unable to accept return of patients into their care.

47. By way of a recent example which is not reflective of the universal attitude of all aged care services that we interact with, but is considered representative of the challenges that our clinicians regularly face, an elderly patient who has a PICC line inserted and no longer needs to be in the acute care system should be able to be transitioned back to their care facility. However, despite HNELHD offering education to that facility staff, and high levels of intervention and support to the aged care facility, the facility did not feel able to accept the patient while the PICC line remains in place. As a consequence, the patient remained in the acute care system, contrary to our aim to support patients in their home environment wherever possible. Additionally, we have patients occupying acute beds but not requiring acute care, thereby impacting on length of stay, and ultimately transfer of care and other activity targets under our service agreement and ABF model.

48. To improve collaboration with Residential Aged Care Facilities (**RACF**), HNELHD has recently developed the Residential Aged Care In-Reach service. This model combines virtual and in-person services to RACF residents and staff to reduce the risk of unnecessary transfer to hospital and to facilitate timely discharge if an acute hospital stay is required.

D. HNELHD's FUTURE STRATEGY

49. The Board monitors HNELHD's performance against the *HNELHD Strategic Plan 2021 – 2026*, exhibited (MOH.0010.0665.0001), looking at the six domains of strategic priority. A monthly finance and performance report is produced that monitors performance against the service agreement and the strategic and operational plans. This report is provided monthly to the Executive Leadership Team and to the Finance and Performance Committee of the Board.

50. The strategic plan must align with state and national priorities. Where the Board adds value in the strategic planning process is through continuous interaction with the CE and executive, as well as through the interaction of Board committees with the executive and relevant staff. There are state based priorities that the district must comply with, however there is latitude for local adaptation, considering local culture, resources, and the specific needs of our population.

Innovation

51. HNELHD has introduced a range of virtual care services, which provide greater access to services, particularly in our rural and regional communities. One example is the introduction of the My ED Doctor service to rural and regional Emergency Departments (**EDs**). The service is provided by My Emergency Doctor and ensures communities have access to 24/7 medical coverage. This has also resulted in staff feeling better supported, reduced travel for patients and has reduced unnecessary patient transfers. At the Board meeting in Muswellbrook, we heard firsthand how that model has prevented people from being transferred to Maitland or other hospitals, by providing expert intervention on site in the Emergency Department.

52. The Mental Health First Responder (**MHFR**) service is another example. 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.

53. Ms McCosker and the Executive, in collaboration with our clinicians, manage a number of such virtual care initiatives. The Executive monitors the quality and safety of these initiatives and provides information up through the governance chain, for review by the HCQC.

54. Last year, the Board examined virtual care models in place elsewhere, such as South Australia, and discussed the need to enhance our virtual care and virtual hospital models, beyond the virtual ED programs for clinicians and My Virtual Care for patients. This is currently being pursued by the Executive.

55. The Board is kept informed of innovation and new models of care, through integration with HMRI and presentations to the Board. By way of example, we have recently received information from Prof Levi about a new pilot program to assist paramedics in the early identification of stroke. For rural and regional areas, being able to implement innovation and new models of care to provide access to treatment earlier, and without relying on tertiary level services, is an important future direction.

Associate Professor Martin Cohen

16 September 2024

Date

Katrina Jane Griffin

Witness: [insert name of witness]

16 September 2024

Date