Special Commission of Inquiry into Healthcare Funding

Statement of Lydia Dennett

Name:	Lydia Dennett
Professional address:	Coffs Harbour Health Campus, 345 Pacific Highway, Coffs Harbour, NSW 2450
Occupation:	General Manager, Coffs Harbour Health Campus, Coffs Network Coordinator, Mid North Coast Local Health District

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

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

A. INTRODUCTION

3. I am the General Manager of the Coffs Harbour Health Campus (formerly known as Coffs Harbour Base Hospital), and the Coffs Clinical Network Coordinator for the Mid North Coast Local Health District (**MNCLHD**, **the LHD**). I report to Stewart Dowrick, Chief Executive of the MNCLHD.

4. The Coffs Clinical Network includes clinical facilities within the northern area of MNCLHD and includes Coffs Harbour Health Campus, Bellinger River District Hospital, Macksville District Hospital and Dorrigo Multi-Purpose Service (**MPS**).

5. In my role as the Coffs Clinical Network Coordinator, my responsibilities include oversight of the day-to-day management and performance of the hospitals within the Coffs Clinical Network. I am responsible for the effective and efficient management of the clinical services within the Network. I am also responsible for ensuring that Service Agreement key performance indicators (**KPIs**) are met, overseeing and managing budgets and the implementation of financial strategies to manage the operating expenditure budget, quality and safety assurance, consumer complaints management, and overseeing recruitment, staffing, and services provided in the Coffs Clinical Network.

6. My role as General Manager of the Coffs Harbour Health Campus involves the effective and efficient management and operation of clinical services in the hospital. My role also

includes managing the delivery of high quality and safe clinical services in the hospital, deployment of resources within the overall budget allocation, people management, emergency preparedness and response as required, incident management, risk management, and participation as an Executive in the MNCLHD Executive Leadership Team.

7. My direct reports include the following roles, which are located in the Coffs Clinical Network:

   a. Network Director of Medical Services,

   b. Executive Officers/Directors of Nursing at Bellinger River District Hospital and Macksville District Hospital,

   c. Director of Nursing and Midwifery at Coffs Harbour Health Campus,

   d. Nursing Manager at Dorrigo MPS,

   e. Whole of Health Nurse Manager

   f. Network Aboriginal Health Manager, and

   g. Network Finance Manager.

8. I have held my current roles for approximately three and a half years. Prior to this, I held senior health leadership roles in Victoria, Queensland and South Australia across the past 20 years. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0610.0001**).

B. CHALLENGES

9. There are key challenges faced by Coffs Harbour Health Campus and the Coffs Clinical Network. They relate to patient flow and access, and workforce.

(i) Patient flow and access

10. Issues with patient flow and access manifest in the form of increasing Emergency Department (**ED**) presentations (with peaks during the holidays), high 'Did Not Wait' statistics for Aboriginal patients above the NSW stage average (7.8% for Coffs Harbour, compared to a 6.5% state average), increased average length of stay across ED to acute

and subacute areas, decreased discharges by 10am and/or midday, and access to and efficiency of theatre utilisation.

11. Underlying factors are increasing complexity and comorbidities in an ageing population, limited access to residential aged care and National Disability Insurance Scheme services, limited clinical in-reach to residential aged care facilities due to the absence of a formal aged care outreach service, and limited access to Hospital in the Home (**HiTH**) and unclear admission criteria. There has also been a significant reduction in bulk-billing General Practitioners (**GP**s) in the community which I believe has led to an increase in ED presentations and increase in acuity of ED presentations. In addition, the difficulty in recruiting sufficient nursing staff has resulted in the non-operation of 10 beds in Bellinger River District Hospital, and 6 beds at Dorrigo MPS, and has necessitated the flexing down of beds (that is, temporary reduction of bed capacity) within Coffs Harbour Health Campus periodically when emergency or unplanned leave cannot be replaced.

12. Opportunities for MNCLHD to address these challenges include:

    a. Establishing an aged care outreach program for the LHD;

    b. Developing a standardised multidisciplinary HiTH model of care across the LHD, including for surgical patients (for example, with same day surgery);

    c. Reviewing the roles, responsibilities and management of those tasked with managing patient flow to ensure clarity of purpose;

    d. Reviewing the role of the preadmission clinic, and optimising theatre schedules;

    e. Increasing the use of peripheral hospitals such as Bellingen and Macksville where able, noting the constraints on the type of patients that can be accommodated at these facilities.

13. Related to access and flow challenges are the challenges surrounding the transfer of patients to tertiary facilities where required. The transfer of adult patients to tertiary hospitals is currently governed by NSW Health Policy Directive PD2018_011 *Critical Care Tertiary Referral Networks and Transfer of Care (ADULTS)* (**MOH.0010.0580.0001**), and PD2011_031 *Inter-facility Transfer Process for Adults Requiring Specialist Care* (**MOH.9999.1211.0001**). As there are no tertiary hospitals in the LHD, patients often need to be transferred for treatment that cannot be provided

within the MNCLHD. The usual tertiary hospital for transfer is John Hunter Hospital (**JHH**), in Hunter New England Local Health District.

14. Overall, the system does work and there is an inbuilt escalation pathway. However, there are challenges in moving patients to higher acuity facilities.

15. Firstly, the retrieval service out of JHH has been reported by our senior clinicians to be a source of delay and frustration given the difficulties experienced in trying to get patients accepted for transfer. It is understood that bed availability is challenging for all hospitals given the demand from both internal and external sources. A retrieval service is particularly important to support hospitals that serve a population with acute care needs that cannot recruit / retain sufficient expert/specialist staff (for example, for complex airway support in a patient that may have suffered trauma and injuries to face and neck).

16. A number of discussions have previously been had with the Director of Medical Services and the General Manager at JHH in the last couple of years, with a view to resolving these issues. Since that time and during the last 12 months, I am not aware of any incidents logged in our incident management system relating to issues/problems/difficulties with retrievals. The NSW Policy related to adult retrieval services (referred to in paragraph 13 above, **MOH.0010.0580.0001**) dictates the pathways to be followed for retrievals includes an example internal escalation process. Coffs Harbour Health Campus has developed and implemented an internal escalation process in particular for time critical patients. That escalation process involves the Director of Medical Services in the first instance and then myself as General manager if required, and then the Chief Executive if his assistance to facilitate an accepting facility is required. In the last 12 months I have not been contacted by any clinicians in relation to any instances where there have been difficulties with a patient retrieval.

17. Second, the next most frequent challenge is the inability of JHH, from time to time, to accept patients.

18. Third is a general difficulty getting access to tertiary care, anywhere, when beds are limited. For example, for local Level 5 services in vascular surgery there is too small a medical workforce with two Visiting Medical Officers (**VMOs**) at each end of the LHD to always provide a timely subspecialty service, and while access to tertiary facilities is an essential safety valve, patients are (anecdotally) not accepted on occasion.

19. By way of further example, until recently we did not have a Neurologist in Coffs Harbour and neurology services were being provided by JHH. Following the recruitment of a VMO

Neurologist in Coffs Harbour, JHH advised that they would no longer provide a Neurology service to MNCLHD patients requiring referral. This has meant that when the single VMO Neurologist goes on leave or is on unplanned leave, the Hospital is left without Neurology cover.

20. In particular there are significant challenges for mental health patients requiring access to a Mental Health Intensive Care Unit (**MHICU**) bed. These challenges include availability of beds, and once a bed has been secured, the need to sedate and restrain the patient during retrieval to a MHICU, which can involve placing the patient on a ventilator for the safety of the patient and the staff accompanying the patient. Delays have been experienced accessing MHICU beds, in particular where the patient has a combination of an acute severe mental health illness in combination with an acute physical illness. MNCLHD has developed an internal flow chart including escalation pathways.

21. Similar to paragraph 16 above, I have only been required to intervene on one occasion when there were delays in a patient being accepted by a tertiary ICU – this was approximately 20 months ago.

22. The Ministry of Health has also advised via IB2024_013 published on 6 March 2024, *Adult Critical and Specialist Care Interhospital Transfer* (**MOH.0010.0579.0001**), that NSW Health Policy Directive *Adult Critical and Specialist Care Inter-Hospital Transfer* will be released in 2024, with five new interhospital transfer priority categories and a clear pathway to escalate transfer delays or issues.

(ii) Workforce

23. MNCLHD confronts significant workforce and recruitment challenges. In the three and a half years that I have worked for the LHD, I have had significant difficulties in recruiting a permanent Director of Medical Services (**DMS**). I have only recently been able to recruit a permanent DMS, who commenced 8 weeks ago. I was largely reliant on locum DMS's prior to the new DMS's commencement.

24. In terms of medical officers, there are difficulties in recruiting and retaining registrars, and some specialists. Coffs Harbour Health Campus is reliant on locum vascular specialists, gynaecologists, obstetricians, anaesthetists, medical registrars, and paediatricians intermittently. Some key subspecialties are only available in low numbers (nationally and locally), impacting on recruitment. For example, anaesthesia, psychiatry, and interventional radiology. MNCLHD is facing a difficult situation with two robust level

5 services that are too far apart to "bulk up" for critical mass, especially for emergency interventional care.

25. There are also significant shortages in nursing. Nursing vacancy rates (advertised positions unfilled by permanent staff) within the Coffs Clinical Network area are as follows:

    a. Coffs Harbour Health Campus - 12 months ago I had 167 full-time equivalent (**FTE**) nursing vacancies, which has now reduced to 67 FTE.

    b. Dorrigo MPS - there is a 50% nursing vacancy rate and as a result I have had to close the 6 acute beds in that facility as a result.

    c. Bellinger River District Hospital - there is a 15% nursing vacancy which has started to reduce, however I have had to close 10 beds in this facility as a result of shortages.

26. To overcome nursing shortages, we have relied on agency staff and the LHD has recruited 187 nurses from the United Kingdom. This recruitment process takes approximately 12 months and some of those nurses are now starting to arrive and commence work.

27. An associated challenge for agency nurses and international nursing recruits is accommodation. In my General Manager role, I am responsible for a large number of leases for residential accommodation. The current housing market has created significant problems for staff in securing accommodation, so we have had to support staff with interim or short-term accommodation, particularly, our new nurses arriving from the United Kingdom. This has been a significant time and financial expense for the MNCLHD and requires that I am, in effect, a property manager.

28. Budgetary constraints have led to Ministry of Health requirements to reduce expenditure. I am required to decrease FTE by just over 100 at Coffs Harbour Health Campus. The challenges associated with this are that there is an increase in the number of patients presenting to the ED and acuity of patients that present to the ED that require increased resources. The length of stay for inpatients within the hospital has increased significantly in comparison to pre-COVID. The length of stay for patients in the ED requiring admission has increased in the last 4 years from 4 hours to 6 hours. In addition, there is

an expectation that elective surgical patients will receive their surgery within the clinical urgency category and its specific timeframe, which translates to beds being occupied.

29. Therefore the ability to reduce frontline clinical staffing (that is already experiencing vacancies) or close beds is not a viable option for MNCLHD to reduce FTE. To reduce the ancillary, administrative and non-clinical staff just creates greater burden on the clinicians and I would argue that the Hospital is already operating at minimum levels. There is always the option to examine and improve efficiencies and we have done that by improving our compliance with Nursing Hours Per Patient Day, reducing the use of overtime, reducing the use of expensive agency nurses, trying to optimise the use of locum staff, examining our policy with regard to increased nursing resource usage for patients requiring increased observation or levels of care and improving our practice – these have been achieved without needing to decrease the frontline clinical workforce. Whilst these efficiencies have resulted in improved financial results, it is insufficient to ensure that the LHD can achieve financial sustainability and operate within the budget it has been provided, therefore the FTE reduction target for me to achieve over the next 2 years is 112.

C. OTHER INITIATIVES

30. A number of new services have been introduced to address service gaps and issues in MNCLHD. Examples are set out below.

31. I have recently overseen the introduction of a Pacemaker Implantation Service, which commenced in June 2023 at the Coffs Harbour Health Campus. The Pacemaker Implantation Service was introduced in response to community demand for the service, noting that prior to the introduction of the service, patients requiring a pacemaker were required to travel to JHH in Newcastle, and sometimes to Sydney, which resulted in additional cost to those patients and their families. This service was introduced and operated within existing funding, that is, there was no funding provided for me to operate this service.

32. The program has been very successful, and we have performed approximately twice as many implantations as initially anticipated. Fortunately, there was a Cardiologist already performing pacemaker implantation at the local private hospital, and he became a VMO at the Coffs Harbour Health Campus. We then provided additional training for staff in the Cardiac Catheter Laboratory and were able to implement that service.

33. Other initiatives have been introduced, such as a Virtual Health Service, which was introduced during the COVID-19 pandemic. The Director of Integrated Care, Allied Health and Community Services is responsible for overseeing the delivery of this service.

34. A large part of my role also involves collaborating with other service providers, such as NSW Ambulance via a daily safety huddle, the North Coast Primary Health Network (**the PHN**, particularly by a quarterly meeting with the PHN Director of Operations), and Galambila (the local Aboriginal Medical Service), to provide continuity of care and aim to reduce presentations to hospitals in the Coffs Clinical Network area.

35. In December 2023, the PHN opened an Urgent Care Centre (**UCC**) in Coffs Harbour. Since the introduction of that service, I have met regularly with representatives from the PHN to connect with the work the UCC is doing and discuss how they can support the work that the MNCLHD is doing, and vice versa. Initially, many overflow patients were referred to the ED to be seen and also to request a referral for pathology and/or radiology services. The service was operated by one GP, one nurse and one administration staff so their opening hours were restricted to begin with and it seems to have taken some time to be able to operate from 0800-2000hrs, however we are beginning to see some improvement with less patients being diverted to the ED. As the service has only been operational for about 9 months, it is too early to evaluate.

36. Finally, an opportunity for MNCLHD is the further development of public outpatient clinics for public patients, which is challenging in rural and regional settings.

D. ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH AND WORKFORCE

37. The Network Aboriginal Health Manager reports to me and, in turn, there are 4-5 Aboriginal Health Workers that report to the Manager. The Chief Executive of Galambila is on the Board of the MNCLHD and I meet with her regularly to discuss our systems and continuity of care for our Aboriginal consumers.

38. We are currently examining the possibility of running an antenatal clinic at Galambila.

39. In addition, we have recently received funding for an Aboriginal Health Nurse Practitioner who will work across Galambila and in the ED at Coffs Harbour Health Campus to try to address high re-presentation rates of Aboriginal consumers. This is supported by a 48-hour follow-up service and also an Aboriginal Health chronic care worker.

40. A range of services are provided to support and assist Aboriginal consumers to access culturally safe and appropriate health services. Examples are Aboriginal Health workers working with local communities to provide health education, working in schools to provide education regarding respectful relationships (Love Bites), an Aboriginal Health Worker with skills and knowledge in Domestic Violence providing support and assistance to Aboriginal consumers exposed to domestic violence, Aboriginal Health Worker support to clinics, integration with other related community health and education programs. The Coffs Clinical Network has a number of Aboriginal Health Workers, based at Macksville District Hospital and Coffs Harbour Health Campus predominantly.

41. Aboriginal Health Workers are also located in the EDs during business hours, at both hospitals to address unplanned returns or readmission of Aboriginal patients, and / or those who choose to leave the ED at their own risk or did not wait to be seen by medical staff. Aboriginal Health Workers follow up discharges from hospital of Aboriginal consumers within 48 hours to encourage connection with a GP for ongoing care/treatment, to address any questions, and to provide advice to consumers in management of their health. Similarly, those with chronic conditions are also followed up in and post discharge from hospital.

42. The Aboriginal Maternal and Infant Health Services (AMIHS) provides antenatal and post-natal care for Aboriginal and/or Torres Strait Islander families in my Network at Coffs Harbour Health Campus and Macksville District Hospital.

43. There are currently 9 Aboriginal school-based trainees across Coffs Clinical Network studying Certificate programs, being 3 Health Service Assistant roles at Coffs Harbour Health Campus and Macksville District Hospital, and 3 in Administration roles (1 each at Coffs Harbour Health Campus, Macksville District Hospital, and Bellinger River District Hospital. Two are in their final year at Coffs Harbour Health Campus of Certificate III Health Service Assistant studies (that is, a Nursing pathway).

44. MNCLHD also offers Aboriginal Nursing and Midwifery cadetships to support Aboriginal and Torres Strait islander people who are enrolled in an undergraduate nursing or midwifery degree at university. There are currently three Aboriginal nursing cadets in the Coffs Clinical Network. All three have completed clinical rotations across three different sites, including Macksville, Dorrigo, and Coffs Harbour. All three are set to graduate this year and will commence in GradStart positions within MNCLHD in 2025.

45. The LHD also participates in the Elsa Dixon Aboriginal Employment Grant program which subsidises the salary, development and support costs of Aboriginal employees in public service agencies and local government authorities.

E. OTHER

46. I have reviewed the statement of Dr Shehnarz Salindera dated 8 August 2024 (**SCI.0011.0342.001**). Relevant to my role, and in addition to the topics set out above, I provide the following comments.

47. The NSW Health system that enables VMOs to claim for their services is called VMoney Web (**VMoney**). I am not directly involved in the VMO payments, however my understanding is:

    a. VMoney claims are routinely checked for compliance;

    b. Payment delays are rare and usually due to the unexpected absence of a delegated approver due to emergency leave or illness;

    c. At paragraph 20 of her statement, Dr Salindera states there are claims she had approved in mid-May 2024 that have not been paid by July 2024. It is my understanding that these were paid and met the Key Performance Indicator of payment by 45 days or less from the submission date.

48. In relation to the on-call surgery roster, it was previously 1 in 6 at Coffs Harbour Health Campus. Dr Salindera raised the on-call frequency with me across several meetings in 2023. This resulted in a plan to enable a functional 1 in 8 roster, via an additional VMO general surgeon, and a Provisional Fellow appointed in 2024. A further VMO surgeon within the 2024/2025 financial year will also be considered. Any flow on effect for surgical waiting lists is a separate issue and not a barrier to increasing the number of surgeons, as experience has shown with the implementation of a 1 in 8 roster.

49. In terms of leave processes for a VMO, there is a process in place. This involves completion of a leave request form which is submitted to the Director of Medical Services for approval. The leave request form indicates whether a Locum will be required to cover the leave period. On one occasion of leave in September 2023, Dr Salindera expressed a desire to arrange her own Locum cover which I understand was approved. The leave was approved by the Director of Medical Services and a combination of Locum and in-house cover was organised.

Lydia Dennett

12/9/2024

Date

Witness: Vanessa Sinclair

12.09.2024

Date