Special Commission of Inquiry into Healthcare Funding

Statement of Stewart Dowrick

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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 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 Mid North Coast Local Health District (**MNCLHD, District**), a position I have held since January 2011.

4. In this role, I am responsible for the functioning of MNCLHD, including the planning and delivery of health services. I am accountable to the MNCLHD Board in the exercise of my functions as Chief Executive. I lead a team of over 4,100 full time equivalent (**FTE**) staff. The District has over 200 Visiting Medical Officers (**VMOs**) and is supported by a vast range of volunteers and stakeholders across all sites and services.

5. A copy of my curriculum vitae is exhibited (**MOH.0010.0605.0001**).

B. OVERVIEW OF MNCLHD

6. The geographical area comprising the jurisdiction of the MNCLHD extends from the Port Macquarie Hastings Local Government Area in the south to Coffs Harbour Local Government Area in the north and provides healthcare services across an area of approximately 11,335 square kilometres.

7. Traditional custodians of the land covered by MNCLHD are the Gumbaynggirr, Dunghutti, Birpai and Nganyaywana nations.

8. It is estimated that in 2024, more than 231,346 residents live within MNCLHD. People of Aboriginal and Torres Strait Islander heritage make up 8.2% of the population, compared to 4.2% for all NSW. This information has been provided by NSW Government Planning.

9. An estimated 13% of residents were born overseas. Coffs Harbour has a growing number of refugees settling in the area. The main refugee communities come from Afghanistan, Burundi, Congo, Eritrea, Ethiopia, Iraq, Liberia, Myanmar, Sierra Leone, Sudan and Togo. Smaller numbers of migrants also reside in Laurieton, Wauchope and Port Macquarie.

10. Over the next decade, MNCLHD's population is expected to increase by 7%. The largest increases are projected for the Coffs Harbour and Port Macquarie Hastings local government areas in accordance with NSW Department of Planning published population projections.

11. MNCLHD's health services include:

    a. Seven hospitals:

        i. **Bellinger River District Hospital**: a 42-bed facility (D1 Community Acute with Surgery) providing a range of services including 24-hour emergency medicine, general medicine, rehabilitation and palliative care services, and Day Surgery (Ophthalmology and Gastroenterology). The Hospital works closely with Coffs Harbour Health Campus as a part of the Coffs Clinical Network.

        ii. **Coffs Harbour Health Campus**: a 357-bed, level five teaching hospital for medicine, nursing, and allied health which also acts as a hub for health research in the region. The hospital provides a broad range of general and specialist services including general medicine, general surgery, specialist medicine and surgical services, including planned and emergency operating theatre surgical services and day only surgery. The hospital also has a coronary care unit (including coronary angiography unit), a large intensive care unit, obstetrics, paediatrics, a 24-hour emergency department, oncology, palliative care, stroke, acute renal dialysis, mental health services (including high dependency) and outpatient clinics.

        iii. **Dorrigo Health Campus**: a Multi-Purpose Service with 27 beds (six inpatient and 21 aged care) as well as a 24-hour emergency department. A limited

range of community and allied health services are also available, including home care packages and ambulatory care services on an outreach basis from Coffs Harbour Health Campus.

iv. **Kempsey District Hospital**: an 81-bed, level three facility with a level four 24-hour emergency department and a range of specialist services including high dependency, general medicine, surgical day procedures, obstetrics, drug and alcohol, mental health, renal dialysis and rehabilitation.

v. **Macksville District Hospital**: a 28-bed, acute inpatient unit and a 24-hour emergency department with medical coverage and telehealth capabilities to connect into Coffs Harbour Health Campus' Emergency Department. Two operating suites provide a range of surgical interventions and incorporate a weekly infusion day therapy unit. The Hospital's midwifery services comprise a Midwifery Led Group Practice model and an onsite Tresillian Residential centre. A range of medical and allied health specialists regularly visit the facility. A variety of community services are provided both from within the facility and servicing the Nambucca Valley. Within the wider Nambucca Valley, NSW Health operates a six-chair satellite Renal Dialysis unit situated at Nambucca HealthOne, which provides additional community services, along with the Bowraville HealthOne centre.

vi. **Port Macquarie Base Hospital**: a 269-bed, level five facility with a 24-hour emergency department. The Hospital provides a broad range of general and specialist services including general medicine, general surgery, specialist medicine and surgical services, including planned and emergency operating theatre surgical services and day only surgery. There is a range of specialist services provided including intensive care, cardiology, geriatric, stroke, respiratory, oncology, renal dialysis, general medicine, orthopaedics, urology, vascular, general surgery, mental health, paediatrics and obstetrics. The hospital also has a coronary care unit (including coronary angiography unit).

vii. **Wauchope District Memorial Hospital**: a 26-bed, level three facility with a seven day per week Urgent Care Centre open 8am and 6pm, and a range of specialist services including day only surgery, day therapy infusion service, palliative care and rehabilitation.

b. 12 community health centres:

i. Bellingen Community Health

ii. Bowraville HealthOne

iii. Camden Haven HealthOne

iv. Coffs Harbour Community Health

v. Dorrigo Community Health

vi. Kempsey Community Health

vii. Macksville Community Health

viii. Nambucca HealthOne

ix. Port Macquarie Community Health

x. South West Rocks Community Health

xi. Wauchope Community Health, and

xii. Woolgoolga Community Health.

12. MNCLHD accommodates the natural flow of patients from bordering Local Health Districts (**LHDs**) and communities such as Taree, Tamworth, Armidale (Hunter New England LHD) and Grafton (Northern NSW LHD). The main services provided within the broader network include radiation and medical oncology, surgery and cardiology.

C. FUNDING

13. MNCLHD receives funding from the Ministry of Health (**MOH**) intended to be commensurate with the estimated cost of complying with its service and performance expectations set out in the annual service agreement. A copy of MNCLHD's *2024-25 Service Agreement* is exhibited (**MOH.0010.0598.0001**). MNCLHD is funded by a combination of Activity Based Funding (**ABF**) and small hospital funding, Multi-Purpose Service (**MPS**) funding and block funding.

14. The ABF Services budget is set by multiplying the ABF target (National Weighted Average Unit 24 (**NWAU 24**)) against the State Efficient Price which is currently $5,675.

For LHDs, such as MNCLHD, a Projected Average Cost (**PAC**) is currently $5,685 which is very close to the State Efficient Price.

15. The MPS program and Residential Aged Care are allocated funding using their District and Network Return cost plus escalation and is funded under the MPS component of the 2024-25 NSW Small Hospital Funding Model, with the Residential Aged Care and Home Care components also partially funded through the Commonwealth Department of Health and Aged Care.

16. ABF has provided more transparency around funding and has reduced clinical variation and improved service efficiencies. Information and data available is much richer and more useable in the context of understanding complex healthcare inputs, cost structures and clinical outcomes. However, the revenue targets set by MOH for ABF funded facilities are difficult to achieve given the demographic profile of the MNCLHD population. The LHD has a degree of relative disadvantage, higher than the State average, as reported by the Social Economic Indexes for Areas published by the Australian Bureau of Statistics. MNCLHD has a low level of collection of revenue associated with private patients in our public facilities. In the 2022-23 financial year, the State average rate for private patient encounters in the acute stream was 18%, but in MNCLHD it was 12% (Source: ABM Portal).

17. The ABF model, as a mechanism for funding LHDs based on type and volumes of services provided, is primarily a hospital acute service model and does not effectively address the financial burden imposed on LHDs as a consequence of broader socio-economic factors impacting healthcare and importantly health outcomes. The inflexible application of ABF in NSW Health does not always ensure that LHDs are funded adequately to support innovation and meet community needs. The ABF model needs to accommodate the application of some discretion to ensure that LHDs with considerable population disadvantage, such as MNCLHD, receive an appropriate share of the State health budget.

18. The recent changes to Patient Remoteness and Indigenous Adjusters in the NWAU 24 version, further negatively impact regional LHDs more than metropolitan LHDs through the reduction of funding for patients who reside in remote areas and indigenous patients, whom predominantly are serviced by regional LHDs.

19. MNCLHD values our small hospitals and the role they play in providing local health care. The District has been intentional in ensuring our small hospitals have a clear role and

purpose, which is aligned with the needs in the community as well as broader networked service models. For example, in alignment with our growing ageing population we have seen a growth in sub-acute services for palliative care, rehabilitation and maintenance type patients. Our smaller hospitals have been pivotal in supporting the District with managing this growth. They also provide surgical services, which has been essential to the District managing demand for planned surgery. All our small hospitals, other than Dorrigo MPS, have experienced an increase in services and FTE since 2018-19. Bellingen's NWAU has increased by 3% and bed days reduced by 6%. Wauchope's NWAU has increased by 15% and bed days by 12%. This service and FTE growth is not aligned with the population growth in the smaller communities, where population growth is much lower than the major centres of Port Macquarie and Coffs Harbour. However, the service growth does reflect District-wide population and service growth.

20. When I reflect on the period of 2011-2020 and compare this to the operating environment associated with the COVID pandemic I believe it is reasonable to suggest that this first decade was more operationally stable. The pandemic years and post period has resulted in the District experiencing significant VMO and workforce structural challenges impacted by the strong job market, low unemployment rates and high levels of sick leave following the COVID-19 pandemic. In addition, activity and inflationary pressures have given rise to increases in the cost of clinical related goods and services, power and utility costs impacting the MNCLHD's financial performance. MNCLHD is continuing to work with MOH on a 3-year recovery plan. As part of that plan, MNCLHD is strengthening its financial recovery by implementing a range of workforce and operational efficiency strategies.

21. At the same time, MNCLHD has been experiencing demand for health services rising above the rate of population growth in the District and well above the NSW rate of presentations per 100,000 population. In the 2022-23 financial year, MNCLHD's rate of unplanned emergency department presentation per 100,000 was 56,859, which has grown by 7% since 2018-19 when it was 53,282. For NSW, over the same period the growth was 2%, with a rate per 100,000 in the 2022-23 financial year reported at 36,543 and 35,802 in the 2018-19 financial year (source: HealthStats NSW). The MNCLHD average annual population growth rate for the same period was 0.7%.

22. MOH, through the Service Agreement and supplementation letters, provides a degree of certainty in regard to funding. To strengthen this process, having certainty around general growth allocations would assist with service planning. Having a three-year funding cycle that reflects service growth would improve service planning and there have

been past models that reflect this. In 2000-2001, the then Area Health Services were advised in advance of general growth funding that would be applied over the following three years. This meant the Area Health Service was aware in 2000-2001 they would receive $8 million dollars above the general growth, the following year $9 million and the year after $18.8 million. These amounts also included a capital component. This advance notice of funding improved the opportunity to plan with our clinicians and communities how these funds would be distributed at the time.

23. In my view, whilst the ABF model is an effective comparator of cost and price, it should be adapted to incorporate more outcome-based funding measures and population-based funding allocations. Examples of this relate to the present modelling of Aboriginal Health and the growing impacts of virtual care and health in the home initiatives.

D. PLANNING

24. In 2022, MNCLHD's *Strategic Plan 2022 - 2032* (**the Strategic Plan**) was finalised, a copy of which is exhibited (**MOH.0010.0599.0001**). It was developed with reference to MOH's *Future Health* strategy (**MOH.0001.0320.0001**).

25. MNCLHD has developed a *Planning and Accountability Framework* (**Framework**) which provides direction to ensure all planning and accountability activities contribute to cohesive strategic management. The Framework outlines the District's approach to strategic management based around a cycle that incorporates strategy formulation, strategy execution and performance monitoring. It also provides guidance, outlines responsibilities and identifies steps and standards to support successful strategic management. The Framework, which is exhibited (**MOH.0010.0600.0001**), aims to ensure the strategic objectives are reflected in all organisational planning. In 2024 as part of the District's Financial Sustainability Program, MNCLHD developed a *Performance and Accountability Framework*, aimed at strengthening performance, accountability and alignment of organisational priorities to strategic objectives. The Framework is in final stages of endorsement and a copy is exhibited (**MOH.0010.0633.0001**).

26. MNCLHD is currently in the process of working on a *Healthcare Service Plan* (**HCSP**) which is a comprehensive planning document that provides the service direction and priorities for a LHD/Specialty Health Network (**SHNs**) over a five-to-ten-year horizon, with specific focus on the issues which affect the health of the catchment population and the delivery of services. In the *Corporate Governance and Accountability Compendium for*

NSW Health (**the Compendium**) (**MOH.0010.0256.0001**), LHDs and SHNs have a responsibility to effectively plan services over the short and long term to enable service delivery that is responsive to the health needs of its defined population. The HCSP is to consider an appropriate balance between investments in various services. The HCSP will also consider the provision of safe and efficient health care within the available recurrent budget through the ABF framework and the best approach to service delivery. This is the planning mechanism where value for money opportunities are investigated and may include partnering with other service providers, public or private, not-for-profit and / or other non-governmental organisations, increasing focus on prevention and early intervention for example. The HCSP has a specific focus on health care needs, service delivery and capacity to meet needs, while our *Strategic Plan 2022 - 2032* sets out MNCLHD's vision and purpose, with focus areas and objectives that help to align the District's priorities to achieve the vision. The Chair of the MNCLHD Board is leading this process and it is due to be finalised early in 2025.

Capital planning

27. Emergency department presentations across the MNCLHD have increased by 14% from the 2018-19 financial year to the 2023-24 financial year, with an average annual growth rate of 2.7% which is, once again, above the population growth rate for the District. The biggest increase has been in Port Macquarie, which has experienced a 32% increase for the same period or annual average growth rate of 6%. In June 2024, MNCLHD received $265 million to update the Port Macquarie Hospital emergency and maternity departments, to address a need in these areas identified though MNCLHD's clinical service planning. The Port Macquarie Clinical Service Plan (**MOH.0010.0601.0001**) supports the capital investment proposal which is primarily focused on the aging infrastructure (1994 build). Additionally, this includes enhancement to maternity, emergency department and other services.

28. Prior to 2021, MNCLHD was involved in an extensive capital program that resulted in major developments at Port Macquarie Base Hospital, Kempsey District Hospital, Coffs Harbour Health Campus and building a brand-new Macksville District Hospital. Additionally, other important capital works have occurred at other facilities across the MNCLHD. Since 2022, MNCLHD is involved in a modest capital works program to the Bowraville HealthOne facility.

29. MNCLHD has submitted proposals for major infrastructure projects as part of the NSW Capital Investment Proposal process for projects that will address critical infrastructure

needs for the District. These projects have been assessed as meeting the NSW prioritisation requirements and are included in the 10 Year NSW Capital Infrastructure Plan.

30. Despite those projects being nominated for inclusion in the 10 Year NSW Capital Infrastructure Plan, there is no certainty of funding for them and no timeline for funding has been made available. These unknowns limit the LHD's ability to inform key stakeholders, particularly our clinical team members, as to when projects will come online.

31. MNCLHD has an ageing building profile that will require significant investment in maintenance and in some cases investment in new builds to deliver clinical services required by the community and reflect standard models of care. For MNCLHD, there are 26 buildings over 40 years old. Of these, 10 are over 70 years old and two are over 100 years old. These buildings have significant functional and performance issues which need to be addressed. Many of these buildings are utilised for community health and health support services.

32. The small community hospitals across the MNCLHD play a key role in delivering networked surgical services, sub-acute services and emergency department care, with the exception of Wauchope, which transitioned to an Urgent Care Centre in place of the emergency department. The role of the small community hospital is crucial for communities and supports the MNCLHD in ensuring residents of the District can access their care closer to home and in a more timely manner, while easing the pressure on the major centres.

33. Noting the age of these small community hospitals, infrastructure issues are reaching a critical point, and while patient admissions and bed days is not comparable to the larger regional hospitals, or those in a metropolitan setting, their role is important in a rural setting. Targeted capital investment is needed for small rural hospitals if they are to continue providing contemporary and safe healthcare for the community and become more digitally enabled and environmentally sustainable facilities.

34. Ten per cent of MNCLHD's major medical equipment (equipment greater than $250,000) is between 10-15 years old. MNCLHD submitted capital investment proposals for priority replacement of major medical equipment, which was estimated to cost just over $19-20 million, but no funds have been allocated over the past three years. Some examples of major medical equipment that are running out of capital sensitivity (meaning that they

will no longer enable clinicians to attract Medicare rebates) include Port Macquarie, Coffs Harbour Bellingen, Wauchope and Kempsey patient monitoring equipment; mobile imaging intensifier, District laparoscopic equipment, and replacement of the cardiac catheter laboratory at Coffs Harbour. Other equipment has reached end of life, meaning that there is no longer technical support or spare parts and no service contracts available. Some examples of such equipment include Wauchope and Coffs Harbour's X-ray rooms and aortic balloon pumps, and Coffs Harbour's echo-ultrasound machines.

35. Maintenance funding levels are typically based on a historical allocation of funding, with adjustments applied each year as appropriate. The MNCLHD Asset Management Plan and Strategic Asset Management Plan outline the maintenance and infrastructure priorities for MNCLHD and the impact of current funding on whole of life asset costs and asset performance outcomes. The Plans highlight the shortfall between current repair, maintenance and replacement (RMR) budget allocations and the amount needed to appropriately address priorities.

36. MNCLHD has undertaken several projects as part of the NSW Health Asset Renewal Program, but with this Program coming to an end, with considerable shortfalls, MNCLHD confronts the problem of there being no other funding sources and uncertainty around future funding.

37. Having contemporary and safe health care environments yields better therapeutic outcomes for our healthcare consumers and assists with attracting and retaining our health workforce. Having more surety of funding for capital investments to address critical priorities, major medical equipment replacements and ongoing maintenance of facilities and equipment is crucial for rural LHDs particularly as there is limited opportunity to raise substantial funds through community and individual philanthropy.

Consultation

38. Capital and service planning requires consideration of new, high value services, rather than an expansion of pre-existing services. However, changing services requires extensive communication with the community and consumers so that they understand the proposed changes and can participate in discussions on decisions that impact them.

39. Community involvement requires consultation with stakeholders such as councils, MPs and community groups and having open discussions with those stakeholders about planning services to equitably cover the community. For example, MNCLHD undertook a 'place-based' planning approach when completing Clinical Service Plans for Bellingen

(**MOH.0010.0602.0001**) and Wauchope (**MOH.0010.0603.0001**). A 'place-based' planning approach was adopted to understand and meet the particular challenges of local health services in Bellingen and Wauchope and the catchment community. This approach was taken in acknowledgement of a need to think differently about service planning for rural health services that face unique challenges, and to adopt a holistic approach to addressing these challenges, accounting for local demographic, socioeconomic and environmental factors. As part of this approach, consultation initially focused on the identification of local health needs through engagement with local service providers and private sector agencies, community groups, local and State governments and their relevant agencies.

40. For each of its capital developments, MNCLHD has had extensive community engagement and examples of this include the Macksville Hospital redevelopment with a strong focus on Aboriginal cultural appropriateness and Wauchope Urgent Care Centre and Kempsey Hospital redevelopment.

E. WORKFORCE

41. MNCLHD is the largest employer on the Mid North Coast (**MNC**), employing just over 4,100 FTE in 2024. Total FTE has grown by 17 per cent or 590 FTE since 2018.

42. Structural workforce issues have contributed to a considerable increase in workforce costs associated with a strong job market, low unemployment rates and a buoyant clinical staff agency market following the COVID-19 pandemic. The workforce structural costs include the significant premium labour charges incurred by the MNCLHD including Overtime, Agency Fees, Sick Leave escalation, Staffing Accommodation and Relocation costs. A comparison of these costs from the 2018-19 financial year to the 2023-24 financial year have increased by approximately $30 million. The following are some examples of these increases:

    a. Nursing agency fees have increased by $7.7 million, whilst nursing agency Salaries & Wages increased by $2.3 million.

    b. Medical agency fees have increased by $1.2 million, whilst medical agency salaries & wages increased by $5 million.

    c. Overtime costs have increased by $6.5 million and sick leave costs have increased by $4.3 million.

d. The District is paying $1.6 million more for staff accommodation.

e. Nursing Staff relocation costs have increased by $2.2 million.

43. The Rural Health Incentive Workforce program has been important to assisting MNCLHD recruit hard to fill and critical positions. Currently the LHD has 27% of its FTE roles defined within these categories.

44. The increasing demand for locums to provide medical coverage not just in NSW but across the nation has directly impacted on the market for these services, with increasing locum rates placing considerable pressure on MNCLHD. This highlights a need for a more coordinated approach across the healthcare system on locum rates to ensure the rural health system can remain sustainable and continue to provide high quality care to the community.

45. A particular challenge for MNCLHD is the rising costs of owning and renting houses. The average median house price in Port Macquarie was $787,000 in the March 2023 quarter and in Coffs Harbour it was $785,000, which is rivalling capital city costs in some parts of Australia. There are challenges with access to short-term and long-term housing accommodation for healthcare staff, compounded by low rental vacancy rates, growth in population, competing government projects in the region, and increasing competition for accommodation.

46. There needs to be state-wide strategies that attract staff to the regions and better negotiation for sustainable financial arrangements with agencies and the contingent labour force. An example being the NSW Whole of Health Nursing Agency Panel.

47. More recently, MNCLHD has updated its partnerships with universities to strengthen existing relationships to improve our ability to attract a future healthcare workforce. An example of this is the updated partnership with the University of New South Wales (**UNSW**) and Charles Sturt University which supports two rural medical training schools in our footprint. The new partnership with Charles Sturt University entered into recently has allowed the District to have an additional rural medical undergraduate program. The aim is to increase educational opportunities in rural local health districts which have been considered an important factor in longer term recruitment and retention of medical staff to these regions.

48. MNLCHD has implemented a range of workforce and management strategies to reduce the District's reliance on premium labour. This has led to a reduction in agency nursing

and an 8% reduction in nursing overtime in the 2023-24 financial year. An example of this is for the first time the MNCLHD embarked for an overseas nursing recruitment strategy. This has resulted in approximately 69 additional nurses starting this year to date with an expected impact of 134 nurses arriving by March 2025. The District has had a very strong focus on reducing overtime and improving rostering practices. This has seen premium full time equivalent percentage reduce from 5.8% (June 2023) to 3.6% (June 2024).

Medical

49. In the 2023-24 financial year, MNCLHD had an average of 348 Junior Medical Officers and 71 Senior Medical Officers, and 8 Career Medical Officers employed. In addition to this, MNCLHD has contracts with over 200 VMOs across our sites and services. In relation to MCNLHD's medical workforce, we have had historical struggles recruiting in the fields of mental health and psychiatry and have relied on locums to fill those positions. The UNSW full medical program started in 2017 and our partnership with UNSW Rural Clinical Campus has seen the District provide 378 individual medical student placements between January 2023 and June 2024. Additionally, in 2023, the District supported the Charles Sturt Medical Program with student placements supported.

50. I have read the statement of Dr Salindera (**SCI.0011.0342.0001**). In relation to the funding of training positions at Coffs Harbour Hospital, MNCLHD supports, as much as possible within its budgetary constraints, the funding of accredited training positions.

Nursing

51. MCNLHD employs approximately 2000 FTE nurses. Historically, MNCLHD has obtained nursing graduates from our four partner universities, the University of Newcastle, Southern Cross University, University of New England and Charles Sturt University. These partnerships have been in place for many years and since 2023 there have been new partnerships entered. These include, for example:

    a. District-wide teaching and supervision with the University of Newcastle (2023).

    b. Work Integrated Learning Collaborative (WILCO) with Southern Cross University to support student placements at Coffs Harbour Health Campus (2023).

c. Collaborative agreement with Charles Sturt University for student placements at Port Macquarie Base Hospital (2023).

d. "Grow Your own" initiative with University of New England (2024), to support student placements.

52. Retention rates for nursing staff across MNCLHD saw a considerable decline from 93% recorded in June 2020 to 89% in June 2023, which has now increased to 92% in July 2024. Since that time there has been an improvement, following an overseas recruitment drive undertaken by MNCLHD in late 2023, to address nursing workforce supply. This recruitment drive centred on attracting nursing staff from the United Kingdom. Approximately 134 nurses have accepted offers of employment. As at August 2024, 69 had commenced employment and a further 53 will commence by March 2025. Despite this, MNCLHD does still struggle staffing smaller sites such as our MPS at Dorrigo where vacancy rates can sit at 50%. Those vacancies are often filled by agency staff.

Allied Health

53. In 2019, Allied Health FTE was 335, representing 11.62% of the overall workforce profile. Presently, there are 410 FTE of Allied Health within MNCLHD, and though this is additional FTE count, it is now only representative of 9.7% of the overall MNCLHD workforce across 17 Allied Health professions.

54. During COVID, MNCLHD did not experience the same changes in retention rates that was experienced in Nursing FTE roles. Since June 2019, retention rates for Allied Health staff have been just under 93% and in June 2024 this retention rate sits at 92%. During the intervening years, retention rates for Allied Health professions was greater than 90%.

55. An important recruitment challenge for the MNCLHD is recruiting allied health to our smaller sites and services due to the issue of critical mass. By that I mean that for the District's small sites and services there usually only enough funding for a fractional (less than 1) FTE Allied Health role which makes it difficult to fill such positions. However, many of these Allied Health roles form part of a District service stream which helps with professional development and education of these Allied Health staff based in our smaller sites and services.

56. MNCLHD has strong partnerships with all universities within the region and supports clinical placements across Allied Health to assist with building and supporting a new graduate pipeline in the local area. The District does not have a formalised Allied Health

New Graduate program or specific New Graduate positions in Allied Health, which exist in other clinical workgroups.

Aboriginal and Torres Strait Islander

57. MNCLHD has increased its Aboriginal workforce from 1.5% in 2012 to 5.8% (June 2024). This increase has primarily been achieved through a Cadetship program, arranged with TAFE as well as local schools, to encourage Aboriginal and Torres Strait Islander students to embark on local Health careers which include nursing, Allied Health, administration, and corporate services. MNCLHD is also working on becoming more culturally sensitive and making facilities safe, particularly for Aboriginal workers (as well as patients). Coffs Harbour, Macksville, Kempsey and Port Macquarie have access to Aboriginal Hospital Liaison Officers, and in addition, there are Aboriginal Cultural rooms at Macksville, Coffs Harbour, Kempsey and Port Macquarie. Aboriginal Artwork by local artists is also incorporated through most facilities. The District also uses the Aboriginal Cultural Engagement Self-Assessment Tool (ACESAT). For staff, there are a number of forums such as the MNCLHD Aboriginal Health Staff Forum and Aboriginal Health Leadership Collective.

Programs to address workforce challenges

58. Partnerships with universities and overseas recruitment, have been crucial to assisting us to recruit to our healthcare workforce.

59. Housing costs in the region, particularly by the coast, is a challenge, and moreso for overseas workers. I have been approached by private enterprise seeking to develop accommodation services for key workers and this will be an area of ongoing dialogue.

60. MNCLHD has applied the Rural Health Incentive Scheme for many critical or hard to fill roles. Although administratively cumbersome for the District, it is an important incentive. My view is that incentives would be better paid as a lump sum to remove the administrative burden and make it clearer to staff that the payment is an additional incentive or bonus. That is not so clear where the payment is absorbed into / comprises part of the employee's annual salary.

F. CARE INTEGRATION

61. Integrated care is a concept centred around delivering care that meets a person's whole health needs, particularly across primary care, acute care, and other services. Integrated care, particularly in MNCLHD, is important for the reasons I identify below.

62. Decisions in the primary care sector have considerable impact on our hospitals, particularly emergency departments, which have traditionally been the doorway to healthcare especially when there are no other affordable options available in the community.

63. MNCLHD experiences two specific seasonal peak periods in service activity: winter and summer. In summer, it is well known that general practices across the region close their services over this holiday period placing immense pressure on the public hospital emergency departments.

64. MNCLHD has seen an increase in emergency department activity, the highest of any rural LHD, during the period of 2018 to 2023, when approximately 149,000 people attended its emergency departments. For context, in that period, MNCLHD contained 2.8% of NSW's population, yet had 4.5% of the State's emergency department presentations. An example of this growth in emergency department attendances is related to changes which happened at Kempsey District Hospital. In 2013-14, Kempsey Hospital recorded 21,200 emergency department presentations. This grew in 2017-18 to 29,533 presentations or an increase of 46% over this period. In 2023-24, Kempsey District Hospital recorded 28,300 emergency department presentations which a reflected 33% increase over this decade. These trends are well above population growth.

65. In my view, this increase in emergency department activity is due to changes in the general practitioner model and the way people in the community need primary care services. For example, during this 10-year period at Kempsey District Hospital, there was an increase of 40% in Triage 4 and 65% in Triage 5. These increases reflect 70% of the total increase over the 10-year period. In my experience, this is due to issues such as general practitioner booking availability and the availability of after-hours appointments.

66. In response to the increase in emergency department presentations, MNCLHD has introduced new ways for the community to access primary care.

67. MNCLHD provides a District-wide Virtual Urgent Care service (funded through the Statewide Urgent Care Services initiative). The focus of this service is the provision of

episodic care via Telehealth and Videoconferencing services to prevent patients with non-emergency conditions, presenting to the emergency department. In my view, the challenges in accessing primary care outlined above render it important for the services provided by MNCLHD to be integrated with the primary healthcare system and primary healthcare services. Bowraville HeathOne is an example of MNCLHD, the North Coast Primary Health Network and the local Aboriginal Health Service working together to provide care to a small community, including General Practice, Pathology, Prevention and Response to Violence Abuse and Neglect, Child and Family Health Services, Community Nursing services, and services for mental health, drug and alcohol. This service has proven to be sustainable, particularly in comparison to historic practices in the town, where the community previously struggled to sustain a general practice model. A recent research project conducted under the supervision of Charles Sturt University investigated the impact of the Bowraville HealthOne on rate of emergency presentations to Macksville Hospital emergency department. This study found that while there was no significant impact on presentations the service did reduce the number of low acuity presentations to the emergency department.

68. Bowraville HealthOne is funded by MNCLHD and accredited as a General Practice, following the Commonwealth approving an exemption under sub section 19(2) of the *Health Insurance Act 1973 Cth*. In relation to the funding of this facility, for the 2023-2024 financial year, it was funded via Medicare and the MNCLHD.

69. The other major challenge that MNCLHD faces in our region is the service provision for our aged population. The MNC has one of the oldest populations in NSW, and there are a high number of people seeking and awaiting access to a Residential Aged Care Home. More than often the acute hospitals within MNCLHD see the most vulnerable and complex patients, and the supply and demand across the region is currently imbalanced.

70. The next phase of healthcare governance and administration would benefit from a different approach that is based on accountability across the continuum of care. This could offer a health care model where consumers are truly at the centre of decisions throughout their episode of care and not left seeking services funded at different levels of government. An effective governance and accountability model to create, support and maintain the delivery of quality care involving multiple providers across the social and health sectors is critical.

71. Perhaps now is the time to consider a governance model that ensures both LHDs and primary health networks are accountable to one authority within the geographical

boundaries aligned with natural patient flow and clinical networks. Such a model of governance would support better operational and strategic planning, strategic risk management, workforce planning, along with shared vision and values across organisations, with decision making in the best interest of the whole system.

G. PARTNERSHIPS

Universities

72. For more than a decade, the MNCLHD region has experienced a growing education sector. This has resulted in an expanded range of health-related courses across the four major university providers. Over this period the MNCLHD has welcomed the opportunity to grow our partnership models with the higher education sector. In 2014 the District entered a collaboration known as the MNC Health Research Collaboration, with UNSW, University of Newcastle, Charles Sturt University, Southern Cross University, Durri Aboriginal Corporation Medical Service, Werin Aboriginal Corporation, Galambila Aboriginal Health Service and the then North Coast NSW Medicare Local. Since then, strong partnerships have continued to develop with UNSW, Charles Sturt University, Southern Cross University and the University of Newcastle, with individual Memoranda of Understanding with each of these four partners being executed in 2023 and 2024. These partnerships have enhanced the ability for people to complete a range of key health related degrees locally. MNCLHD partnerships with higher education have enhanced the ability to train and retain the next generation of health professionals, providing workforce pathways in nursing, allied health and medicine. MNCLHD is actively involved with our partners in a range of NHMRC and Medical Research Future Fund research projects.

Primary Health Networks

73. Healthy North Coast (Primary Health Network) and MNCLHD have formal partnering arrangements in place with a joint Board meeting providing a forum for strategic discussions (**MOH.0010.0604.0001**). MNCLHD is working with the Primary Health Network to expand primary care alternative pathways to our services. This includes supporting the Urgent Care models in place such as the North Coast Health Connect service, and the Medicare Urgent Care Clinic through regular engagement, partnership, sharing of strategy and collaborative planning to work towards providing maximum access to the community of the MNC.

Aged care

74. MNCLHD works with aged care providers to manage availability and transfers across our facilities. This is a manual process where managers contact residential aged care facilities each day to obtain bed availability, to be able to move patients appropriately to aged care.

75. MNCLHD is progressing an Aged Care Strategy that aligns to the recommendations in the final report of the Royal Commission into Aged Care Quality and Safety. This body of work is in tandem with MOH progressing through negotiations for NSW and the Commonwealth on the future of Aged Care Service provision. The work being undertaken locally will require ongoing dialogue and collaboration with MOH to ensure alignment with shifting Aged Care landscape, adjustments for statewide transitions into a Single Aged Care Assessment Service, and to ensure NSW Health is able to engage in a tender process.

Aboriginal and Torres Strait Islander

76. MNCLHD has a long-standing formal partnership with Aboriginal Community Controlled Health Organisations (**ACCHO**) in the MNC region. The MNC Aboriginal Health Accord partnership agreement was established to achieve optimal health and wellbeing for Aboriginal people on the MNC with MNCLHD, Durri Aboriginal Corporation Medical Service, Galambila Aboriginal Health Service, Werin Aboriginal Corporation Medical Service and the Healthy North Coast (Primary Health Network) being parties to that formal agreement. A review of the partnership agreement was undertaken in 2023 and a new partnership agreement was entered into from 2024-2029, with all parties confirming the importance of the partnering arrangements and quarterly meetings continuing.

77. A key example of the collaborative work that has been undertaken with one of our ACCHO partners is the opening of the Chronic Care Centre in Kempsey that operates from the Kempsey District Hospital. Both MNCLHD and Durri Aboriginal Corporation Medical Service have invested jointly in delivering chronic care to Aboriginal residents in Kempsey and surrounds through this new centre. A second example that demonstrates shared workforce model is the Aboriginal Maternal and Infant Health Service (AMIHS) that has been collocated at Galambila Aboriginal Health Service for over 22 years. The program offers a holistic wrap around service that includes General Practice, Early

Childhood services, and other services as required to support mothers, babies, and the family.

Other healthcare providers

78. MNCLHD has partnered with Tresillian to provide a residential centre at Macksville Hospital, bringing a service for rural families needing a more intensive level of support in their parenting journey.

79. Partnership with private hospitals have continued to strengthen with collaborative care models in place. During 2023-24, close to 1800 operations were undertaken using this model. Additionally, MNCLHD has had a longstanding surgical partnership with Baringa Hospital in Coffs Harbour that commenced in 2017.

H. INNOVATION

80. MNC Virtual Care provides prompt access to early assessment and intervention for patients. The service has a focus on hospital prevention (i.e. providing appropriate clinical care through Virtual Urgent Care), care navigation and early supported discharge from hospital. MNC Virtual Care has also established strong novel partnerships with NSW Ambulance with inaugural statewide protocols to enable paramedics to provide point of care referrals to the MNC Virtual Care Service, preventing and promoting connection to appropriate care in the appropriate place, at the appropriate time, and reducing the need for unnecessary transfer to emergency departments by emergency services which enables a more sustainable health care service.

81. In 2023-24, MNC Virtual Care provided Virtual Care Services to 7204 unique patients, with 4463 avoided Emergency Department Visits, 959 hospital admissions prevented, 1409 patients being discharged from hospital earlier and 283 direct referrals from NSW Ambulance point of care.

82. The Emergency Mental Health and Acute Addictions Response Team (**EMHAART**) model provides a multidisciplinary team that aims to see all people who present to the emergency department with a Mental Health and/or Alcohol and other Drugs condition within 30 minutes of arrival, providing culturally led, trauma-informed and just restorative care.

83. Since the commencement of EMHAART in February 2023, to end of July 2024 over 5000 people have accessed the services. This has resulted in a reduction in the number of

people with a mental health and/or alcohol and other drug condition staying in the emergency department for more than 12 hours, with a 50 per cent reduction and fewer people staying more than 24 hours in an emergency department. It has led to people receiving responsive care in the right environment including diversion of people to community mental health, alcohol and other drug services. It has reduced our bed occupancy for our inpatient mental health units to approximately 70% and the length of stay to an of average of 8.9 days.

Stewart Dowrick

12/9/2024

Date:

Witness:

12/9/2024

Date: