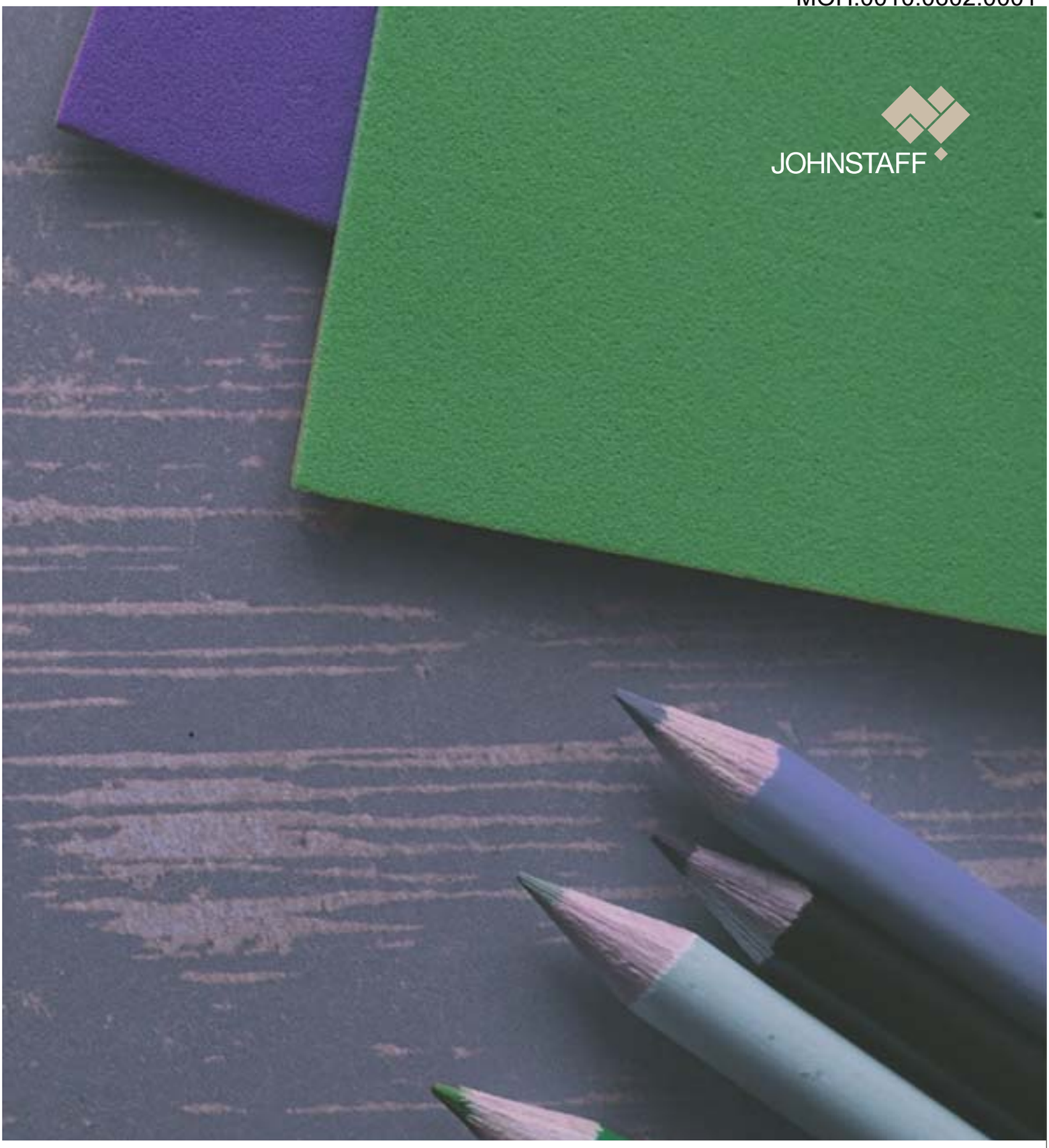

JOHNSTAFF

Service Planning: Bellinger River District Hospital

Mid North Coast Local Health District

Document Control

Document Title:	Service Planning: Bellinger River District Hospital Mid North Coast Local Health District	Copies and Distribution:
Prepared By:	J. Sheehan and K. Favaloro	
Reviewed By:	J. Yacopetti	
Revision:	Version 2.0 - FINAL	
Date of Issue:	November 2020	02/12/20
File No:		
Server Location:	\\granite.johnstaff.lan\Public\Projects\Advisory\A103 MNCLHD Service Planning - Bellinger and Wauchope\6. Outputs and Deliverables\6.1 Project Reports\6.1.1 Drafts	

Acknowledgement of Country

We acknowledge the traditional owners of the land covered by the Mid North Coast Local Health District, the Gumbaynggirr (from south of Grafton to just south of Macksville), Dunghutti (from south of Macksville to half way between Kempsey and Port Macquarie), Birpai (Port Macquarie area), and Nganyaywana (south-east region of the New England Tablelands) Nations. We pay our respects to elders past and present and emerging leaders.

This Plan has been developed in collaboration with the Mid North Coast Local Health District and the community members and local service providers of Bellingen.

Disclaimer: This map indicates only the general location of larger groupings of people, which may include smaller groups such as clans, dialects or individual languages in a group. The boundaries are not intended to be exact. This map is not suitable for use in native title or other land claims.

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1. Executive Summary

A ‘place-based’ planning approach was adopted to understand and meet the particular challenges of Bellingen health services 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. This local input into planning also identified several opportunities to collaboratively meet the specific needs of the catchment community, to form partnerships to maximise the use of existing expertise, services and infrastructure. Mid North Coast Local Health District staff were then consulted to provide their insights service challenges and gaps, with an understanding of the outcome of community stakeholder consultation and the planning approach.

The objectives of the place-based planning approach taken are to:
- Think differently about how health services can be delivered in a way that tis relevant and meaningful for the community
- maximise access to an appropriate range of integrated health and social services
- maximise the use of the regional hospital asset and other local services to benefit the community.

Understanding local context

Stakeholders were keen to ensure that local context was understood and represented in planning outcomes.

In recent years, the Bellingen community and surrounds has experienced drought, bushfires, flooding and the COVID19 Pandemic, all of which have consequences for the health and wellbeing of the community. Climate change and associated weather events were discussed as being of “significant concern” to the local community, which also emphasised a need for the consideration of matters affecting ‘wellness’ rather than just physical health. Mental and social well-being, and a desire for holistic care involving supportive relationships and connections within the community were expressed. In this sense, a strong sense of individual investment and responsibility in health outcomes among local community members was discussed, with the Bellingen Hospital viewed by many as a facilitator of this, increasing an individuals ability to make informed decisions about their health and wellbeing, and connecting them with services across the system.

Bellingen and surrounds was discussed by many as a desirable location to live, and particularly attractive to retirees. For this reason, the catchment population is older, with a median age of 49 years (compared to 38 years for NSW). Another consequence of the desirability of the location is that property prices in Bellingen are high, and private rental properties are both expensive and limited due to people preferring to holiday let their homes. With community / affordable housing options limited, homelessness was raised as an issue by Bellingen community stakeholders, across all age groups.

Also attracted to Bellingen are individuals seeking an alternate or less mainstream lifestyle, and to this point stakeholders provided the low rates of immunisation among Bellingen LGA resident children as evidence. Additional to being older, Bellingen LGA residents are more socio-economically disadvantaged compared to NSW, and as a population have a number of elevated risk factors and indicators of poorer population health compared to NSW as a whole. These include, higher rates of chronic disease, more hospital admissions and increased disease risk factors.

What stakeholders said

The diversity of stakeholders consulted provided a broad spectrum of views. Even so, several commonly occurring themes and key service gaps were apparent, and these, along with an understanding of service drivers and future directions, planning context and current and projected service activity have been used to instruct strategies for future development and change.

Common themes	Key service gaps
Services lack connectivity	Mental health services
	Local public allied health services
Patients have difficulty navigating systems	Access to specialist services
	Health promotion services
System integration is difficult	Services for Aboriginal community members
	Non-emergency transport services

Strategies for future development and change

In accordance with the planning approach, strategies for future development and change are intended to adopt a holistic approach to addressing the health needs of the Bellingen community and involve partners in solutions. Importantly, key planning principles instructed the maintenance of existing service capability level and the continuation of service networking and patient flows between Bellinger River District Hospital and Coffs Harbour Hospital.

MNCLHD Strategy	Action
Establish, or participate in, a forum for service provider networking	1. A representative from Bellingen Health Services should coordinate or attend an established forum for service provider networking. The goal of this activity is to improve the understanding of services available to the community, and the manner in which MNCLHD services connect with these services. The interagency meeting hosted by the Bellingen Neighbourhood Centre (occurring every second month) should be canvassed for suitability. 2. Identify other ways to increase the awareness of service providers operating locally, for example, GPs opening their rooms to service providers for an evening (involving the Primary Healthcare Network). 3. As precedence exists in other jurisdictions, ascertain the potential for joint funding for a community service provider liaison role, to support the forum and facilitate networking between health and social service providers operating in the community.
Harness 'system navigators' to address access inequity	4. Through the provider forum, map those local providers who offer 'system navigators' (e.g. providing support for people to navigate the NDIS and My Aged Care portals), and establish a way to identify and connect community members with these services. Examples might include accepting referrals from education providers to educate and support parents through the NDIS, or in-reach to hospital patients who require support for My Aged Care. Consideration should be given to 'taking these services to the community', identifying areas of high need and finding ways to connect.
Support community wellness, early intervention and hospital avoidance	5. Improve the use of information from other service providers operating within the system, including paramedics providing unscheduled primary health care, and support the correct direction of this information for use by other providers within the system. 6. Increase local access to public allied health services, including those for paediatric patients.
Focus on mental health	7. Map all providers of mental health and wellbeing services within the area, and seek to identify exactly what they provide (and to whom) and how their services are accessed. The goal of this

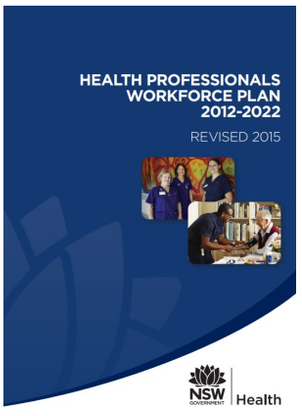
	activity is to increase understanding and connectivity between providers with a view to supporting patient access to the right care at the right time.
Support community involvement in health and health service promotion	8. Canvass community and social service providers who may be able to support the local dissemination of health promotion information and coordination of health promotion activities for the community. For example, Rotary, who was planning a 'health expo', expressed a keenness to take a role in health promotion (including through social media), and the neighbourhood centre provide updates to a local business and community service directory hosted by the council (https://ilovebelloshire.com/). 9. Consider the ability of the local health promotion group to support the MNCLHD Public Health Unit in relation to the provision of information to the local community about immunisation and the NSW Immunisation Program.
Access available infrastructure, looking for opportunities to collocate services	10. Seek to identify suitable locations within the community to collocate health services with social and community services. Examples may include libraries (for navigator services), neighbourhood centres, cross-jurisdiction service providers (for example employment agencies), NGO health service partners and/or providers of other social services.
Provide greater support for discharge planning, patient advocacy and community service provider liaison	11. Increase resources for discharge planning from BRDH to enable improved flow of patients across the system, and support these resources to maintain their awareness of local community service programs and providers, to enable patients to receive optimal care in the right place.
Improve access to non-emergency patient transport	12. Support the early identification of patient transport needs through discharge planning. 13. Advocate on behalf of Health to Transport NSW, for transport solutions linking point to point providers with nominated / scheduled public transport routes. This will require strong engagement with community for-profit transport providers.
Enable better integration between MNCLHD services and improve local service access	14. Enhance the network patient flow model across MNCLHD, working as a hub with transport and smaller sites. 15. Engage with MNCLHD Virtual Care Project Team regarding increasing local access to: a. Public allied health services, including those for paediatric patients (outpatient services) b. Specialist paediatric outpatient services c. Specialist psychiatry outpatient services d. Inpatient specialist services, including psychiatry and geriatrics. 16. Review technical and infrastructure enablers and local support requirements to ensure appropriate implementation of virtual models of care.
Focus on Aboriginal Health	17. Create a culturally safe space within BRDH to support Aboriginal patient and family discussions. 18. Ensure all health and health promotion activities consider the most effective and culturally appropriate manner for communicating with Aboriginal people.

Seek to address homelessness in Bellingen	19. Advocate on behalf of Health for more affordable housing within Bellingen, including to the Bellingen Shire Council who recognises this issue and is working towards improving and addressing this issue through land use planning.

2. Context of the Plan

Under the Health Services Act 1997, Boards have the function of ensuring that strategic plans to guide the delivery of services are developed for the Local Health District (LHD), and for approving those plans. At LHD level Service Plans are required to incorporate the strategic priorities established by the Board.

The NSW Ministry of Health (MoH) is responsible for coordinating and planning system-wide services, workforce, population health and asset planning at a state level. MoH also provides advice and feedback to LHDs on local planning exercises as required, and reviews local planning in respect of achieving whole of system goals and objectives. For example, service plans such as this plan, will be reviewed by the MoH and therefore needs to align with the NSW Government directions and processes.



An annual Service Agreement between the Board of the Mid North Coast Local Health District (MNCLHD) and the Secretary of NSW Health is the 'contractual' arrangement between the LHD and the MoH, and sets out the service delivery, targets and performance expectations for the funding and other support provided to the LHD. This has also been a key reference document for the development of this Plan.

In keeping with the planning framework, this Plan for Bellinger River District Hospital (2020 – 2031) is informed by the *NSW State Health Plan Towards 2021*, the MNCLHD Strategic Directions 2017 - 2021 and by the policy directions of the MoH and clinical guidance developed by statutory organisations such as the Agency for Clinical Innovation (ACI).

2.1 Service Drivers and Impacts

2.1.1 Understanding Challenges for Rural Health Services and Communities

While the needs of each community will be different, there are several commonly occurring challenges that are uniquely faced by rural and remote health services and communities due to their geographic isolation.

Service sustainability

The concept of health service sustainability is particularly important in rural and remote communities. Sustainable health services maintain their benefits for communities and populations beyond their initial stage of implementation and continue to be delivered within the limits of finances, expertise, infrastructure and participation by stakeholders.

Difficulties associated with recruitment and retention of a competent health workforce, maintaining workforce skills and access to training opportunities are common within rural and remote communities. This is acknowledged within *The NSW Health Professionals Workforce Plan 2012-2022,* which is the strategic framework that aims to address the long-term workforce needs of NSW Health and *The NSW Rural Health Plan – Towards 2021*, which outlines strategies to grow the rural workforce, support rural education and training, improve rural workforce planning capacity and provide support to health professionals working in rural areas.

Equitable access to services

Where rural and remote communities are too small to provide local health services (often for safety and quality reasons, but also economic reasons), residents must access care from larger urban centres and access to these services can be problematic.

This may result in health needs not being met, lack of continuity of care and an absence of monitoring of the effectiveness of services in terms of health outcomes.

Poorer health outcomes

On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to multiple factors including lifestyle differences and a level of disadvantage related to education and employment opportunities, as well as access to health services[1].

2.1.2 A Need for Innovation

Rural and remote communities are characterised by a diverse range of health needs demanding a range of approaches to the delivery of health and health-related services. To be sustainable, some of the approaches need to be different from those that are effective and sustainable in cities.

> Acknowledging rural health needs are different than metropolitan health needs, means the response must be different to the models commonly in place in the metropolitan areas

Service sustainability relies on care being delivered in the most cost-effective place by the right provider; which also includes how specialised services can provide effective, acceptable outreach services. **There needs to be a range of flexible options for care and a process for managing the patient journey to ensure care continuity.** Underpinning this is a reliance on skills maintenance and capability of the health workforce.[2]

Today, several examples exist where technology has enhanced the level of service in a rural community through the use of Telehealth. For example, tele chemotherapy has been a game changer for certain towns in outback Queensland.

Within rural areas, integrated care and patient-centred approaches, with established partnerships between a regional health service, the local primary health network and local general practitioners (GPs), are considered as exemplars of an approach needed to support growing community health needs.

2.1.3 Considering Social Determinants in Solutions

It is well documented that health is largely determined by social determinants rather than access to health care services. The social conditions in which people are born, live and work is the single most important determinant of good health or ill health. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces. Place based planning is one mechanism in attempting to address the social determinants of health and assimilate it into the overall response to a community's needs.

Planning for and supporting a local model which enhances opportunities for connections to social elements such as education, housing and welfare information and support can reap both individual and community benefits. Access to and coordination with specific social services are particularly relevant for specific cohorts such as Mental Health, Child and Youth Health and aged care where it is known that health outcomes can be improved.

2.1.4 Drought, Bushfires, Floods and COVID-19

Climate change and associated weather events present an array of challenges for local communities. The on-going impact of the 2019/2020 bushfires on Bellingen Shire's population, along with the impact of the COVID19 Pandemic have consequences for the health and wellbeing of the community (see stakeholder comments within section 'Consultation Process and Outcomes').

[1] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 10 July 2020, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

[2] Allan, J., P. Ball and M. Alston. 2007. Developing sustainable models of rural health care: a community development approach. *Rural and Remote Health* 818 (7).

As evidence, several government agencies and organisations have focused their attention on building existing sustainability drivers and working towards community resilience, including working to address the mental health consequences of increased stress, isolation and loss.

3. Environmental Scan / Future Directions / Policy Framework

3.1 Environmental Scan

3.1.1 Bellingen Shire Council

The Bellingen Shire Council (bellingen.nsw.gov.au) provides services and supports to a Shire it describes as “a lifestyle region with an emphasis on cultural vibrancy, liveability and social cohesion. It has diverged over the years and is now a mix of traditional and non-traditional farming. Many of today's residents are artists, craftspeople, writers, musicians and horticulturalists, with approximately 12.1% of employed residents having established home-based activities.”

The Council takes a role in community health and wellbeing, including health promotion campaigns like ‘Make Healthy Normal’ and resilience programs. The Council also support service provision through as the owner of infrastructure such as the Neighbourhood Centre and the building occupied by the Bellingen Youth Hub, within which services are provided by local General Practitioners.

Other activities of note include support for disability access and inclusion, and working to improve and address the issue of a shortage of affordable housing, including rental housing across the Shire, through land use planning.

Through their website, the Council also supports a community directory with a category for health and family service providers, and the Council has an active social media platform.

3.1.2 The NSW Ambulance Integrated Care Strategy

The NSW Ambulance Integrated Care Strategy focuses on improving the integration and connectedness of initiatives with other health and social service providers, Primary Health Networks and non-government organisations within and across Local Health District (LHD) boundaries. It aims to provide patient-centred seamless, effective and efficient care that responds to all of a persons’ health needs.

Primarily to the changing demographics of patients, the work profile of NSW Ambulance is continuing to evolve from its traditional focus on acute care and transport to one of ever increasing out-of-hospital care provision.

NSW Ambulance has a unique position as the health-care arm of the emergency services and the emergency arm of the health service. The domain of urgent/unscheduled care offers the most opportunity and likelihood for providing care in the home – in consultation with other health service providers using an integrated approach where necessary – with no need for transport to hospital.

The impact of the strategy will be decreased hospital presentations and connecting patients with the most appropriate health care.

> *“Today’s paramedic is a clinician – focusing on the provision of emergency care from unscheduled primary health care through to acute emergency care – contributing to the broader health effort.”*

NSW Ambulance

3.1.3 Department of Primary Industries

Several programs are offered within the Department of Primary Industries that are focused on people, their businesses and their wellbeing. These include:

- The Rural Resilience Program works with primary producers across regional and remote NSW to build personal and family resilience, which is an essential tool to withstand the challenges of rural life and farm-based businesses. While not delivering health services per se, the Rural Resilience team links rural communities, families and individuals with the most appropriate services and information, and provides workshops such as Tune Up For Fellas (TUFF) that aim to build strategies for reducing stress and 'clearing your mind'.
- The Rural Recovery Support Service provides assistance to rural landholders and primary producers who have been impacted by the recent bushfires.
- The Rural Women's Network works in innovative ways to share information and promote action on rural women's issues, often in partnership with individuals, groups and non-government and government agencies. Strategic priorities include building personal and business resilience, and core projects include rural women's gatherings and an annual issues and ideas communique.
- The Young Farmers Business Program, while focused on building business knowledge and skills, has a broad reach across NSW through social media, workshops, coaching and events.

3.1.4 Healthy North Coast (Primary Health Network)

Territory planning is currently underway to assist Healthy North Coast to better understand local needs, improve local service and ultimately achieve better health outcomes for communities and individuals.

MNCLHD has partnered with Healthy North Coast for the North Coast Collective (NCC), which recognises the need for a collective approach to understanding and improving health outcomes – moving from today's silos to embracing regional governance for shared commissioning. This shared approach involves joint planning and priority setting, shared resourcing, and a commitment to pursuing the best return on investment for health outcomes.

The agreed vision for NCC is to transition over time from our current disjointed approach to service commissioning and delivery to a dedicated regional commissioning model, thus recognising that even by delivering 'best practice' programming in our relative sectors we are often still failing to provide joined-up services which consumers can navigate and which result in optimal health and wellness outcomes.

3.1.5 The Bellingen Youth Hub

The $2 million federally funded Bellingen Shire Youth Centre, 'the HUB'; officially opened for business in August 2012.

The centre has a range of services and facilities available for our young people and community that include availability of Youth Workers, a Youth Clinic, learner driver program, various youth initiatives, meeting spaces, exercise room, computer and homework facilities, music room, bouldering wall and an 'ArtPark'.

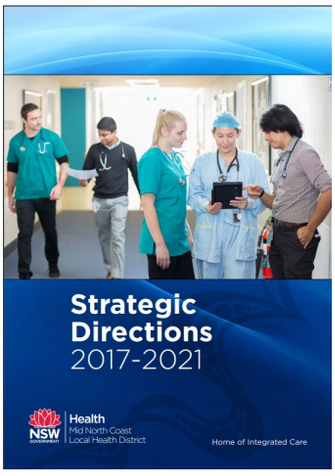
As a result, the centre is a real HUB for many local organisations to operate from, particularly those relating to young people. These include the Bellingen Shire Youth Services, Two Way Street, job employment agencies, community dance, movement, yoga, art classes and more.

3.2 NSW Health Policy Framework

3.2.1 MNCLHD Policy and Planning Framework

The MNCLHD Policy and Planning Framework provides clear direction for service planning and development, including:

- The District's Strategic Directions 2017-2021
- The District's Health Needs Profile 2016
- The District's Clinical Services Plan 2018-2022
- Coffs Harbour Health Campus Clinical Services Plan 2016-2026
- Asset Strategic Plan 2018
- Master Services Plans for sites and redevelopment projects.



3.2.2 Key Strategic Drivers

This MNCLHD Policy and Planning Framework is supported by the NSW Integrated Policy and Planning Framework, which aligns with the Australian Government, NSW Government, NSW Ministry of Health strategic directions.

The key strategic drivers will include:

- National Health Reform Agreement (NHRA)
- National Partnership Agreement on Improving Public Hospital Services including National Emergency Access Target (NEAT) and National Elective Surgery Target (NEST)
- Activity Based Funding

- NSW 2021: A plan to make NSW number one

- NSW State Health Plan: Towards 2021
- Ministry of Health Services Plans, Policies, and Procedures
- A Blueprint for eHealth in NSW
- Health Professionals Workforce Plan 2012-2022
- NSW Aboriginal Health Plan 2013-2023
- NSW Rural Health Plan Towards 2021

3.2.3 Patient Centred Care

New South Wales, national and international health policy recognises that quality health care is person-centred. The NSW State Health Plan emphasises the provision of person-centred and integrated care, "with a focus on empowering patients as a key partner in decision making".[3] This direction is supported by the Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service 'Standard 2: Partnering with Consumers', which requires the involvement of consumers in the organisational and strategic processes that guide the planning, design and evaluation of health services.[4]

[3] NSW Ministry of Health. (2014). NSW State Health Plan: Towards 2021. NSW Ministry of Health, Sydney
[4] Australian Commission on Safety and Quality in Health Care (ACSQHC). (2011, September). National Safety and Quality Health Service Standards. ACSQHC, Sydney.

As the NSW population ages and lifestyles change, more people are living with multiple long-term conditions that can affect their health, quality of life and ability to function. As a result, they may need access to a range of health and hospital services. The last few decades have seen a change in focus to developing health care systems that aim to keep people healthy, rather than just treating people when they are sick. There is recognition of the need to deliver 'the right care, in the right place, at the right time' for everyone and, where possible, to provide care closer to home in the home or primary and community health care settings.[5]

3.2.4 Activity Based Management and Funding

The implementation of a national activity based funding (ABF) system is intended to improve the efficiency and transparency of funding contributions of the Commonwealth, state and territory governments for each Local Hospital Network (LHN) across Australia.

To achieve this, the Independent Hospital Pricing Authority (IHPA) is required under the National Health Reform Agreement and the National Health Reform Act 2011 to determine the National Efficient Price (NEP) to calculate Commonwealth activity-based funding payments for in-scope public hospital services. The introduction of ABF has been central to health care reforms that pursue greater efficiencies in health and hospitals. Under ABF, health care organisations are funded on the volume and type of activity they undertake. The decisions made by IHPA in pricing in-scope public hospital services are evidence-based and utilise the latest costing and activity data supplied to IHPA by states and territories. The funding classification used in ABF comprises a combination of the ICD (latest version) diagnosis and procedure codes and the Australian Refined Diagnosis Related Groups (latest version) for pricing admitted acute services. Tier 2 Non-admitted Services classification (current version) is used for pricing non-admitted services.[6]

Activity Based Management (ABM) will come into place at the Bellingen River District Hospital from the 1st of January 2021 (also backdated from 1st of July 2020).

[5] Patient Experience and Consumer Engagement: A Framework for Action (Agency for Clinical Innovation- Feb 2015)
[6] https://www.ihpa.gov.au/sites/g/files/net636/f/publications/signed_-_pricing_framework_for_australian_public_hospital_services_2017-.pdf

4. Key Planning Considerations and Principles

4.1 A Place-Based Planning Approach

The basis of the planning methodology is the NSW Ministry of Health Services Planning Guide for health services and infrastructure development and investment. This document has heavily informed the structure and content of this Plan.

Additionally, a tailored, **place-based approach** to meet the particular challenges of rural health services and communities, as outlined within Section 2.1.1, has been applied. Place based health planning adopts a holistic approach to addressing health needs for a particular community by accounting for local demographic, socioeconomic and environmental factors. It involves the use of partnerships including local service providers and private sector agencies, community groups, local, State and Federal governments and their relevant agencies to develop and deliver programs and services. Place based planning identifies and prioritises local health needs through the collaboration of some or all of these groups. This collaboration enhances the potential for success. This local input into the planning, but especially the development and delivery of programs assists to ensure the specific needs of the locality are met.[7]

The objectives of the place-based planning approach are to:

- think differently about how health services can be delivered in a way that is relevant and meaningful for the community
- maximise access to an appropriate range of integrated health social services
- maximise the use of the regional hospital asset and other local services to benefit the community.

In meeting this objective, the planning approach taken:

- prioritises local needs in line with the role delineation of the health service
- identifies gaps and uses a process that is open to innovation to address gaps, seeking to identify the best model to fill a particular need
- improves care coordination and service connection outside of the traditional infrastructure silo's
- accounts for both physical and virtual integration
- complements current infrastructure, community assets and identifies redevelopment requirements in line with such.

4.2 Planning Assumptions and Key Planning Principles

The following planning assumptions have been applied to this planning exercise, and are reflected throughout this document:

- residents of the Bellingen LGA form the primary catchment for Bellinger River District Hospital
- Bellinger River District Hospital will continue to provide the majority of services at Role Delineation levels 2 and 3, and will continue to focus on low acute inpatient care, meaning options to address local needs in line with the role delineation of the health service will be prioritised
- service networking and existing patient flows will continue between Bellinger River District Hospital and Coffs Harbour Hospital
- planners will be open to innovation to address identified service gaps, seeking to identify the best model to fill a particular need

[7] Yeboah, D. 2005, A Framework for Place Based Health Planning. *Australian Health Review,* Vol 29 No. 1

- management will focus on improving care coordination and service connection outside of traditional infrastructure silo's - strengthening networks, avoiding duplication and improving linkages across providers of both health and social services
- planning recommendations will account for both physical and virtual integration
- complementing current infrastructure and community assets, and identifying redevelopment requirements in line with such, ensuring that any redevelopment recommendations do not result in an expanded hospital footprint on either hospital campus.

4.3 Methodology for Projecting Service Activity

4.3.1 Inpatient Activity Projections

Future requirements for acute overnight and same day medical and surgical services at Bellinger River District Hospital have been projected to 2030/31 using the NSW HealthApp and CaSPA (Clinical Services Planning Analytics Portal) developed and endorsed by the MoH for use in clinical service planning. The modelling tool takes account of projected population growth and ageing and NSW age and sex specific trends in length of stay and separation rates for Enhanced Service-Related Groups (ESRGs), in the development of projections for inpatient separations and bed days. All acute projections have been projected excluding renal dialysis, chemotherapy, unqualified neonates and acute psychiatry.

HealthApp uses activity and flow patterns as the baseline for projections and assumes a gradual trend towards the State-wide level of utilisation for each ESRG. In calculating bed requirements, the following bed occupancy rates were used:

- 75 per cent for surgical and medical overnight beds
- 90 per cent for subacute overnight beds
- 170 per cent for surgical, medical, maternity, paediatric and subacute same day beds.

4.3.2 Outpatient Projections

The NSW Health projection methodology for outpatient services uses a function of Occasion of Service (OOS) and OOS duration data, with a distinction made for new and review appointments. Assumptions include:

Outpatient activity includes in-person services only and excludes telehealth, phone, email and non-client contact activity. Activity for General Medicine (delivered at an Urgent Care Centre (Tier 2 Code 20.05) and Imaging Services (Tier 2 Codes 30.01-30.06) are also excluded.

As the available data did not provide accurate and consistent session duration times, these have been averaged and an assumption of 60 minutes for new sessions, and 30 minutes for review sessions was used for infrastructure projections.

Infrastructure projections assume the clinics operate 7 hours a day, 250 days a year, at 80 per cent occupancy.

Activity growth projections were developed based on an average annual growth rate for all service activity between 2016/17 and 2018/19.

Outpatient activity was provided by the LHD. This was used to project infrastructure requirements using the NSW MoH approved methodology, where:

- new to review clinic ratios were provided by the LHD
- growth rates were derived from available data and used to project future years of activity
- room requirements were calculated based 240 days per year, 9 available hours per day, and 80% occupancy
- an assumed 30-minute clinic duration was used for calculating infrastructure projections.

5. Introducing the Mid North Coast Local Health District

The MNCLHD covers an area of 11,335 square kilometres, extending from the Port Macquarie Hastings Local Government Area (LGA) in the south to Coffs Harbour LGA in the north. The western and southern borders of the District join the Hunter New England Local Health District.

The MNCLHD has established two geographical networks, which have been drawn with consideration to the facility relationships within each Network.

Port Macquarie Base Hospital is the hub of the Hastings Macleay Clinical Network (HMCN) in the south, within which Wauchope Hospital is located. Coffs Harbour Health Campus is the hub site for the Coffs Clinical Network (CCN) in the north, within which Bellinger Hospital is located. Each Network site is located within 1.5 hours drive of smaller facilities and health services within the respective Networks. The MNCLHD Senior Executive are located at both Port Macquarie and Coffs Harbour.

The two geographical Networks support the development of clear clinical governance processes and quality and safety systems. Networks do not provide boundaries that restrict patients from moving to other Networks to access care.

6. Bellinger River District Hospital

Bellinger River District Hospital (BRDH) is a 36-bed acute and sub acute facility providing health services to residents of Bellingen Local Government Area. Bellingen Hospital provides the majority of services at the NSW Role Delineation levels of 2 and 3 (see Appendix A – Role Delineation).

Bellinger River District Hospital provides a 24-hour service. Medical services are provided by General Practitioners. Surgical services are provided by specialist surgeons and anaesthetists contracted to the Health District.

Services provided include Emergency, General Medicine, Aged Care and Day Surgery. There are no staff medical officers on site. Bellingen Hospital forms part of the network of services across the Health District working closely with Coffs Harbour Health Campus and others as patient needs require.

6.1 Clinical Network

BRDH is located within the Coffs Harbour Clinical Network (CHCN) in the north of the MNCLHD. Coffs Harbour Health Campus is the major referral hospital for the CHCN.

The CHCN covers an area of 4,261 square kilometres and consists of three LGAs – Bellingen, Coffs Harbour and Nambucca. It shares its northern border with the Northern NSW LHD, its southern border with the Hastings Macleay Clinical Network, and its western border joins the Hunter New England Local Health District.

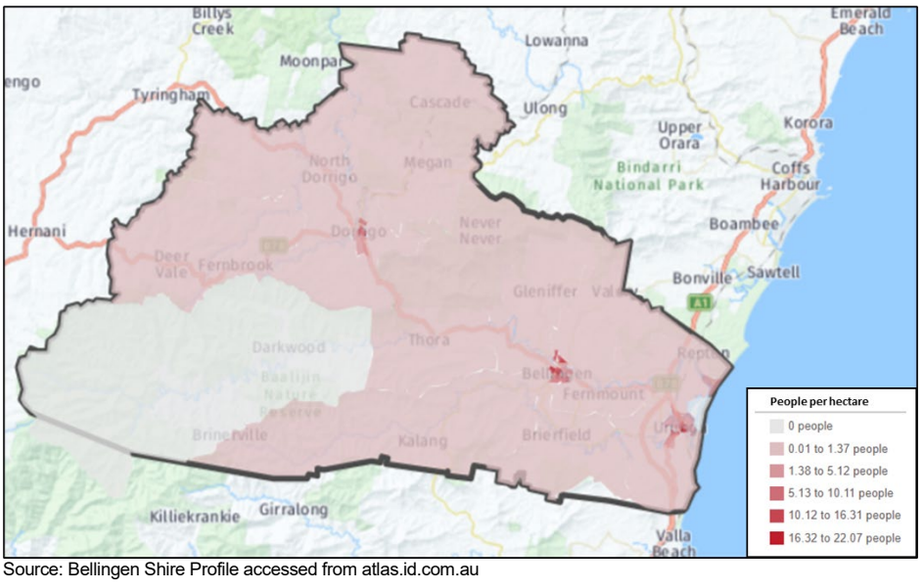
6.2 Profile of the Catchment

6.2.1 Population

As at 30 June 2016, the estimated resident population (ERP) of Bellingen LGA was 12,951 persons, accounting for 0.2 per cent of the NSW population. There were 446 Aboriginal and Torres Strait Islander peoples living in the region in 2016, accounting for 3.5 per cent of the population.

The figure below shows the distribution of the population (population density shown as number of persons per square kilometre) by SA1 for the LGA. The overall population density for Bellingen LGA is 7.91 persons per square kilometre, with NSW reporting 8.64 people per square kilometre.

Figure 1 - Population Density, 2016, Bellingen LGA



Source: Bellingen Shire Profile accessed from atlas.id.com.au

The catchment population has a different spread of age groups compared to the rest of NSW. The population of the region is older, with a median age of 49 years (compared to 38 years for NSW). Approximately 55 per cent of the LGA population was aged 45 years and over (compared to 40 per cent of the NSW population), and 23 per cent were aged 65 years and over (compared to 16 per cent of the NSW population).

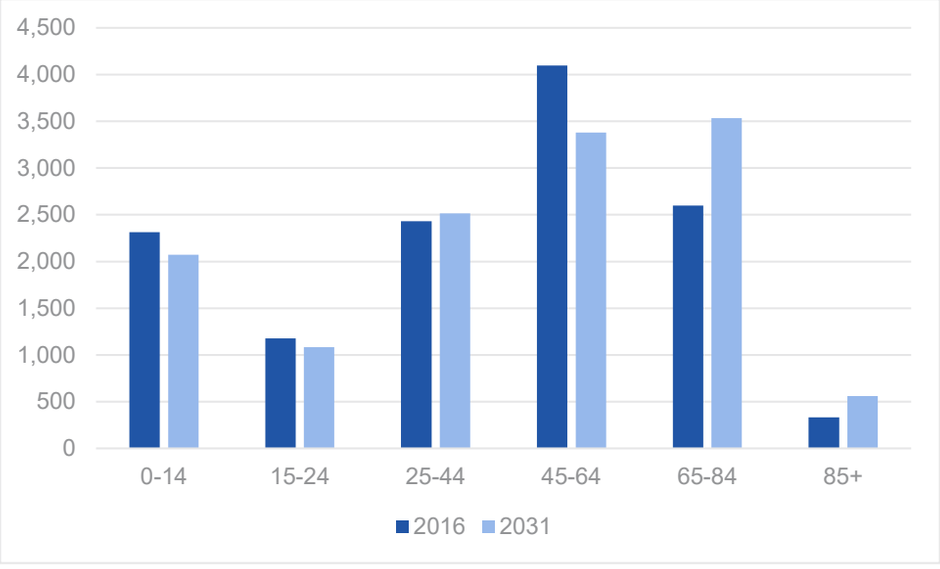
The population is projected to increase to 13,139 people by 2031, an increase of one per cent on the 2016 census, with an annual growth rate (AGR) of 0.05 per cent. The LGA is growing at a slower rate than the NSW population as a whole (AGR of 1.3 per cent). It is projected that the proportion of those aged 45 years and over will increase by 2031, while younger age groups will decrease slightly. By 2031 those aged under 45 years will account for 43 per cent of the population, while those aged over 65 years will account for 31 per cent.

Table 1 - Population Projections by Age Group, 2021 to 2036 for the Primary Catchment

Age Group	2016	2021	2026	2031	% Change from 2016	% of Total 2016	% of Total 2031
0-14	2,313	2,229	2,118	2,071	-10%	18%	16%
15-24	1,177	1,137	1,137	1,083	-8%	9%	8%
25-44	2,431	2,446	2,540	2,514	3%	19%	19%
45-64	4,098	3,861	3,520	3,379	-18%	32%	26%
65-84	2,600	2,984	3,348	3,533	36%	20%	27%
85+	332	410	474	559	68%	3%	4%
Total	**12,951**	**13,067**	**13,137**	**13,139**	**1%**	**100%**	**100%**

Source: NSW DPIE NSW 2019 Population Projections ASGS 2019 LGA projections

Figure 2 - Population Projections by Age Group, Change from 2016 to 2031



NSW DPIE NSW 2019 Population Projections ASGS 2019 LGA projections

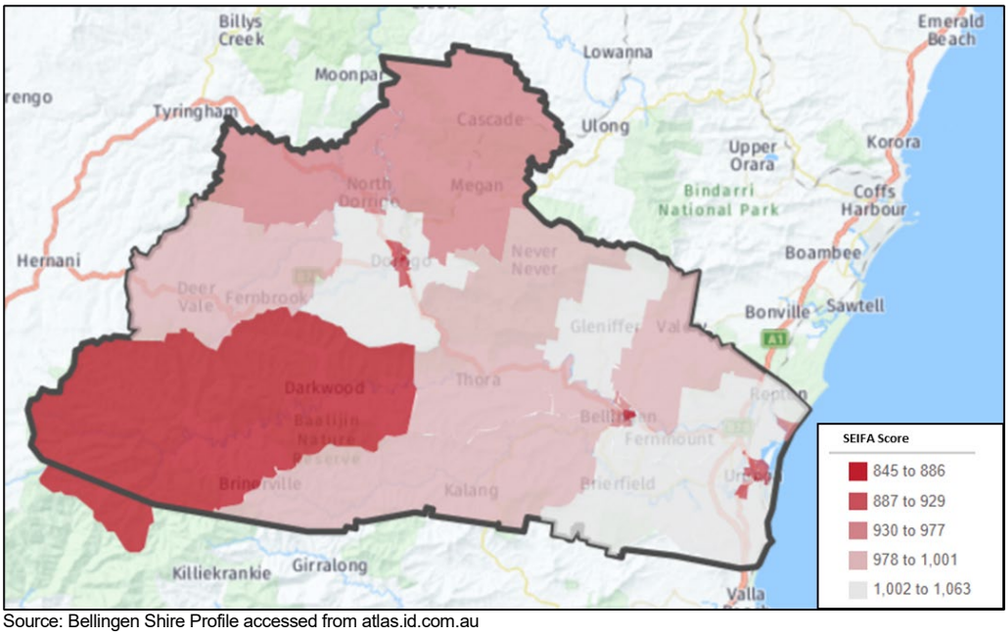
6.2.2 Socio-economic status

The Socio-Economic Indexes for Areas (SEIFA) is a summary measure of the social and economic conditions of specific areas across Australia. SEIFA scores are standardised against a mean of 1,000. The measure can be used as a proxy for health status as there is considerable evidence of the link between low socio-economic status and poorer health particularly in relation to chronic disease. Generally, populations with greater social disadvantage also exhibit lower incomes and reduced formal educational attainment.

Notes on SEIFA: A lower Score indicates that an area is relatively disadvantaged compared to an area with a higher score. Deciles are calculated by ordering all areas from lowest to highest score; the lowest 10% of areas are given a decile number of 1 and so on, up to the highest 10% of areas which are given a decile number of 10. This means that areas are divided up into ten groups, depending on their score. Decile 1 is the most disadvantaged relative to the other deciles. For ranking withing NSW, the area with the lowest score is given a rank of 1, the area with the second lowest score is given a rank of 2 etc.

Notes on Geographic Areas: While SEIFA data was available at SA1 and SA2 levels, these areas do not aggregate well to the corresponding LGA. As such, LGA level SEIFA data was used.

Figure 3 - Index of Relative Socio-economic Disadvantage, 2016, Bellingen Shire



Source: Bellingen Shire Profile accessed from atlas.id.com.au

The latest available data (from 2016), indicates that the LGA had a lower SEIFA disadvantage index score (966) (i.e. higher levels of disadvantage) compared to the standardised Australian average (1,000). The following tables provide additional socio-economic statistics for the LGA, with comparisons to NSW and Australia.

Table 2 - Catchment Socio-Economic Statistics

LGA	Median household income (weekly)	% Unemployed	% with Year 12 as highest education level	Developmentally Vulnerable Children*	% persons born overseas
Bellingen LGA	$997	7.2%	10.6%	12.2%	19.5%
NSW average	$1,486	6.3%	15.3%	19.9%	34.5%
Australian average	$1,438	6.9%	15.7%	21.7%	33.3%

Source: ABS, Census of Population and Housing, 2016; ABS Socio-Economic Indexes for Australia (SEIFA), 2016
*Developmentally vulnerable children are those who are vulnerable in one or more AEDC domains

Table 3 - Catchment Socio-Economic Statistics as at June 2017

LGA	% Age pensioners	% Disability pensioners	% On long term unemployment benefit	% Low income, welfare-dependent families	% Children under 15 in jobless families	Government support as main income in the last 2 years (ASR)
Bellingen LGA	71.3	9.5	8.2	12.7	15.3%	27.9
NSW average	63.2	5.3	3.8	8.8	11.5%	20.4
Australian average	63.6	5.3	4.3	9.0	11.5%	19.9

Source: PHIDU Social Health Atlas of Australia, 2019

Overall, Bellingen LGA is more socio-economically disadvantaged compared to NSW with:

- a higher proportion of persons on disability pension and on age pension (for those 65+)
- a higher percentage of low income, welfare-dependent families and jobless families with children under 15 years of age
- more people receiving unemployment benefits and with government support as their main source of income
- less people completing Year 11 and 12.

6.2.3 Health and wellness Indicators

The population of Bellingen LGA has a number of elevated risk factors and indicators of poorer population health compared to NSW as a whole. These include, higher rates of chronic disease, more hospital admissions and increased disease risk factors.

A summary of selected indicators and risk factors for the region is shown in the table below, with elevated risk factors for the LGA (compared to NSW) shown in red. It should be noted that for a number of risk factors, while the rate is higher than NSW, the actual numbers of persons is low given the relatively smaller population of the region.

Table 4 - Highlighted Health and Wellness Indicators and Risk Factors for Bellingen LGA^

Indicator (%)	LGA	NSW	AUS
Obese adults (aged 18+)	35.9	30.9	31.3
Obese children (aged 2-17)	11.0	7.4	8.2
Current smokers	18.6	14.4	15.1
Alcohol consumption: more than 2 drinks per day	26.1	15.5	16.1
People with mental and behavioural problems	20.7	18.8	20.1
People with high/very high levels of psychological distress	14.1	12.4	12.9
Bowel cancer screening participation in last 5 years (% of invited people undertaking screening)	42.1	38.3	41.3
Breast screen participation in last 2 years (% of women 50-69)	53.2	52.8	n.d.
Adults with Asthma	13.6	10.6	11.2
Adults with Type 2 Diabetes	5.4	5.2	4.9
Adults with Heart / Vascular Disease	4.2	4.9	4.8
Adults with COPD	2.6	2.2	2.5
Adults with Arthritis	15.1	15.5	15.0
Self-reported dental health status as fair/poor	16.2	14.1	14.7
People who experienced a barrier to accessing healthcare in the last 12 months, with main reason being cost	2.2	2.5	2.0
Low birth weight babies (%)	5.7	5.2	6.1
Mothers smoking during pregnancy (%)	15.9	9.8	10.8

Children fully immunised at 5 years of age (%)	80.3	94.6	94.7
Deaths of persons aged 15 to 24 years (ASR / 100,000)	102.8	33.3	35.8
People with a profound or severe disability (%)	6.3	5.6	5.4
Median age at death (years)	80.0	82.0	81.0
Deaths from all avoidable causes (ASR / 100,000)	138.1	116.9	118.8
Cancer	38.3	27.3	28.4
Diabetes	8.2	6.3	6.4
Circulatory diseases	25.9	35.8	35.3
Respiratory diseases	11.3	10.6	10.2
External causes (Falls, burns, self-inflicted)	24.8	12.3	14.3
External causes (Transport, drownings)	24.2	15.1	15.6
Public hospital admissions (excl renal dialysis) (ASR / 100,000)	35,043	38,775	n.d.
Admissions for infectious and parasitic diseases	548.7	608.5	645.8
Admissions for cancer	1,288.6	1,095.8	1,280.6
Admissions for diabetes	168.8	139.1	168.9
Admissions for mental health related conditions	960.7	902.5	965.8
Admissions for nervous system diseases	1,028.1	607.7	786.3
Admissions for ischaemic heart disease	427.5	391.7	396.9
Admissions for stroke	231.8	210.9	213.8
Admissions for respiratory system diseases	1,573.8	1,514.1	1,587.7
Admissions for musculoskeletal system diseases	924.5	958.3	1,000.7
Admissions for genitourinary system diseases	1,257.6	1,067.7	1,178.1
Admissions for injury and other external causes	2,857.9	2,243.6	2,456.0
Potentially preventable admissions for all conditions - Public hospitals (ASR / 100,000)	2,538.7	2,223.7	2,388.6
Potentially preventable admissions for chronic conditions - Public hospitals (ASR / 100,000)	1,202.5	998.1	1,092.4

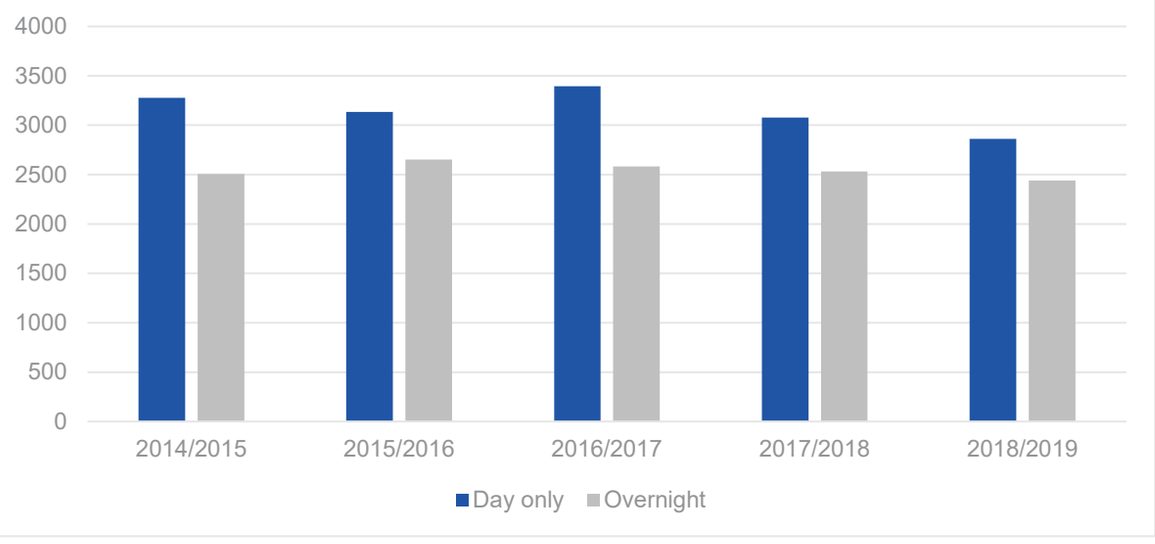
Source: Victorian Population Health Survey 2017, Department of Health and Human Services, Victoria; PHIDU Social Health Atlas of Australia, 2019, PHIDU Social Health Atlas of Australia, 2019
^Values are Aged Standardised Rate (ASR) per 100 unless otherwise noted

6.3 Current and Projected Service Activity

6.3.1 Demand

On an annual basis Bellingen residents demand for inpatient care is 5,700 episodes, on average over the last 5 years to 2018/19. This demand is met by both private and public hospitals and was provided for acute, sub-acute care and inpatient acute and non-acute psychiatry. More than 50 per cent of the total activity was provided on a day only basis as shown in the table below.

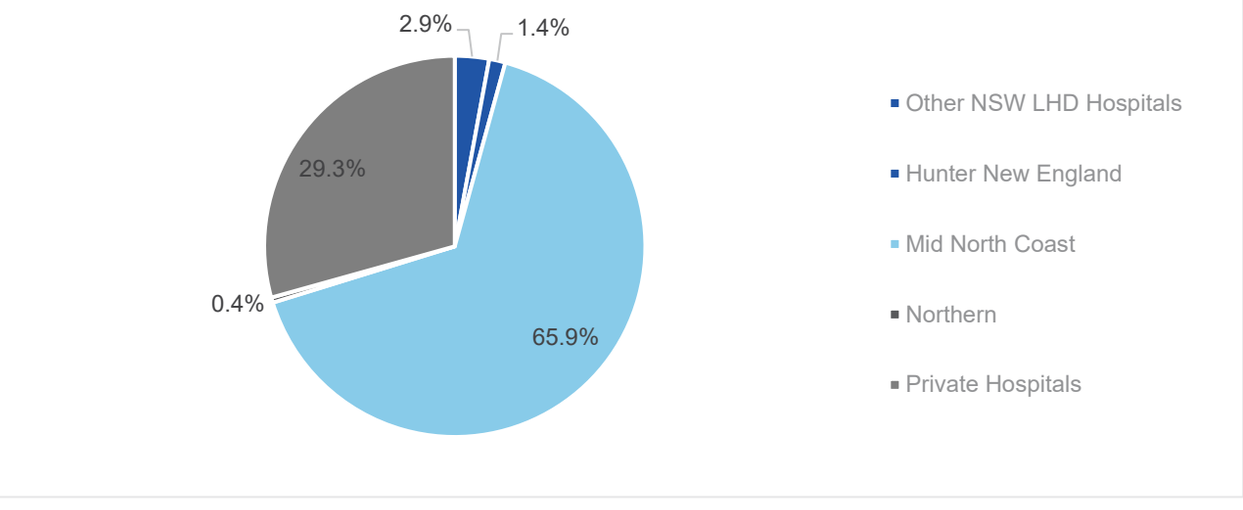
Table 5 - Total Activity, Bellingen LGA Residents, Private and Public Hospitals by Stay Type, 2014/15 to 2018/19.



Source: NSW HealthApp

On average over the 5-year period from 2014/15 to 2018/19, Bellingen residents received the majority of their inpatient care in hospitals within the Mid North Coast LHD (65.9 per cent) and almost another 30 per cent of patients sought their care in a private hospital or day procedure centre, as shown in the chart below.

Figure 4 - Proportion of Bellingen Residents by LHD where they received their Inpatient Care: 2014/15 – 2018/19



Source: NSW HealthApp

Over the 5-year period of 2014/15 to 2018/19, the top five SRGs provided to Bellingen residents were fairly consistent, this includes both private and public acute activity. These 5 SRGs represent 48 per cent of the total acute demand in 2018/19.

Table 6 - Total Acute Episodes, Top 5 SRGs, 2014/15 to 2018/19, Bellingen LGA Residents, Private and Public Hospital

Top 5 SRG	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	Proportion of 2018/19 Total Acute Activity
Orthopaedics	457	490	482	448	481	10.9%
Diagnostic GI Endoscopy	433	422	366	343	370	8.4%
Ophthalmology	396	423	441	455	398	9.0%
Gastroenterology	363	394	390	405	447	10.1%
Non Subspecialty Medicine	303	360	388	391	409	9.3%

Source: NSW HealthApp

In regard to sub acute inpatient activity, which includes the SRGs of Rehabilitation, Palliative Care and Maintenance, the majority of demand from Bellingen residents was supplied by private hospitals, although both Bellingen and Coffs Harbour Hospitals predominantly provided the majority of overnight inpatient care.

Table 7 - Total Sub Acute Episodes, Bellingen LGA residents, Public and Private Hospitals, 2014/15-2018/19

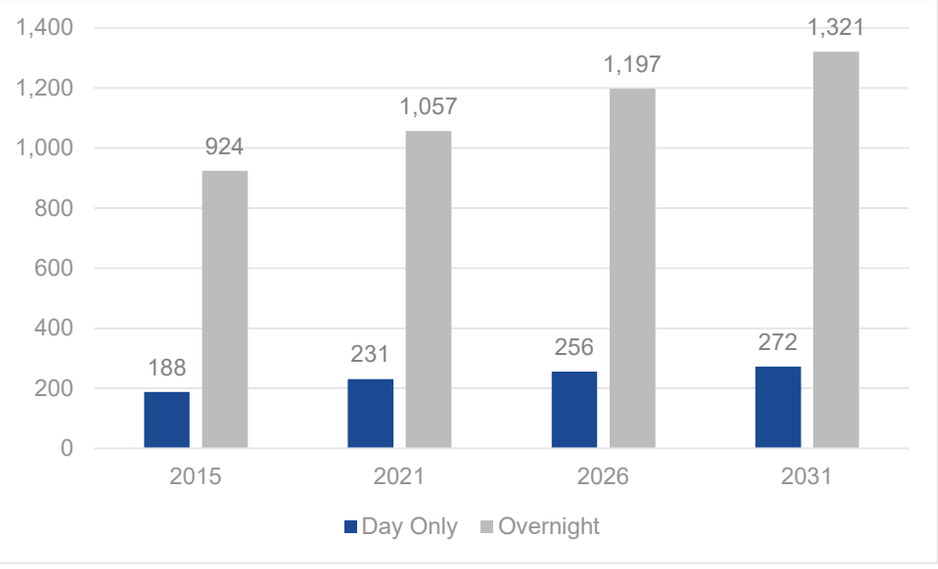
	2014/2015		2015/2016		2016/2017		2017/2018		2018/2019	
Hospitals	Day only	O/night	Day only	O/night	Day only	O/night	Day only	O/night	Day only	O/night
Bellinger River		90		60	1	64	2	75	1	52
Coffs Harbour	23	23	12	31	46	59	78	33	72	39
Private (excl DPCs) Hospitals	186	31	290	24	414	27	182	22	204	41
Other Hospitals	0	22	1	17	0	22	1	11	1	9
Total	**209**	**166**	**303**	**132**	**461**	**172**	**263**	**141**	**278**	**141**

Source: NSW HealthApp

6.3.2 Inpatient Activity

The following figure and table provide a summary of overnight and same day separations at BRDH, as well as the top 5 SRGs (of greatest volume). The largest volume of services is for medical SRGs including Non-Subspecialty Medicine and Respiratory Medicine, which account for 37 per cent of total activity. In 2015, 83 per cent of total activity were overnight episodes, and this pattern is expected to continue with 83 per cent of total episodes expected to be overnight in 2031.

Figure 5 – Total Overnight and Same Day Episodes, BRDH, 2015 – 2031



Source: NSW HealthApp

Table 8 – Total Episodes, Top 5 SRGs, BRDH, 2016

Top 5 SRGs (2016)	Episodes	% Total Episodes
Non-Subspecialty Medicine	188	23.2%
Respiratory Medicine	114	14.0%
Orthopaedics	101	12.4%
Non-Subspecialty Surgery	56	6.9%
Cardiology	54	6.7%
All other SRGs	299	36.8%
Total	**812**	**100%**

Source: NSW HealthApp

Overnight Services

The following table and figure provides details of overnight medical and surgical service activity. Overnight activity at BRDH is primarily for medical services, with very little surgical activity occurring each year.

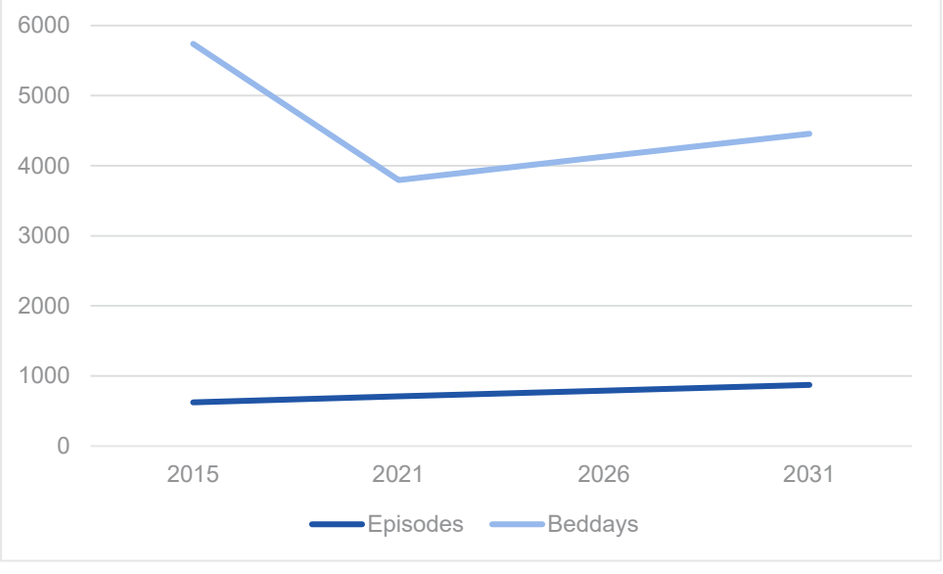
While total episodes will continue to grow, beddays are projected to decrease between 2016 and 2021 from 5,664 beddays to 3,714 beddays, and then progressively grow to 4,060 beddays by 2031.

Table 9 – Total Overnight Episodes and Beddays by Service Type, BRDH, 2016 – 2031

	Episodes				Beddays			
Service Type	2016	2021	2026	2031	2016	2021	2026	2031
Medical	598	671	757	841	5,625	3,639	4,001	4,344
Surgical	13	19	18	17	39	75	59	50
Total	611	690	775	858	5,664	3,714	4,060	4,394

Source: NSW HealthApp

Figure 6 – Total Overnight Acute Episodes and Beddays, BRDH, 2016 – 2031



Source: NSW HealthApp

Same Day Services

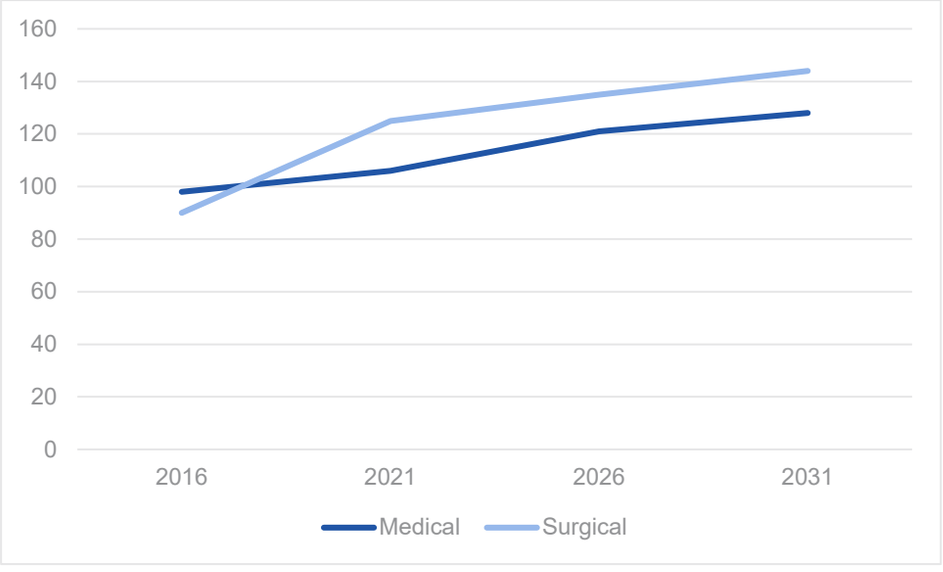
The following table and figure provides details of same day medical and surgical service activity. There is a low volume of same day activity at BRDH. Same day activity is projected to grow from 188 episodes in 2016 to 272 episodes by 2031, representing an increase of 45 per cent.

Table 10 - Total Same Day Episodes and Beddays by Service Type, BRDH, 2016 – 2031

	Episodes				Beddays			
Service Type	2016	2021	2026	2031	2016	2021	2026	2031
Medical	98	106	121	128	98	106	121	128
Surgical	90	125	135	144	90	125	135	144
Total	**188**	**231**	**256**	**272**	**188**	**231**	**256**	**272**

NSW HealthApp

Table 11 - Total Same Day Episodes by Service Type, BRDH, 2016 - 2031



Source: NSW HealthApp

Subacute Services

The following table provides details of subacute service activity at BRDH. Subacute activity is projected to grow from 300 episodes in 2016 (representing 5,159 beddays) to 448 episodes in 2031 (representing 5,748 beddays), representing a 49 per cent in episodes and a 11 per cent increase in beddays.

Table 12 - Total Subacute Episodes and Beddays by Service Type, BRDH, 2016 – 2031

	Episodes				Beddays			
Service Type	2016	2021	2026	2031	2016	2021	2026	2031
Rehabilitation	141	175	216	224	3,086	3,069	3,695	3,777
Psychogeriatric Care	12	13	11	13	234	228	193	228
Palliative Care	91	81	92	104	1,021	680	756	838
Maintenance	56	80	86	107	818	841	797	905
Total	**300**	**349**	**405**	**448**	**5,159**	**4,818**	**5,441**	**5,748**

Source: NSW HealthApp

Emergency Services

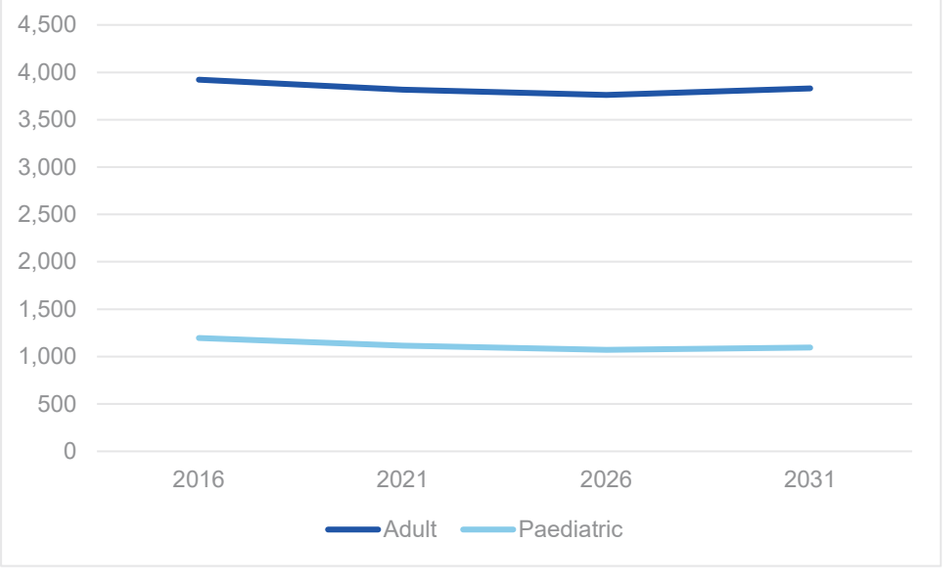
The following table and figure provide details of emergency service activity at BRDH. Emergency activity is projected to decrease from 5,118 presentations in 2016 to 4,926 presentations by 2031, a small decrease of 3.8 per cent.

Table 13 - Total Emergency Presentations by Service Type (Adult / Paediatric), BRDH, 2016 – 2031

	Presentations			
Service Type	2016	2021	2026	2031
Adult	3,922	3,816	3,761	3,829
Paediatric	1,196	1,117	1,071	1,097
Total	**5,118**	**4,933**	**4,832**	**4,926**

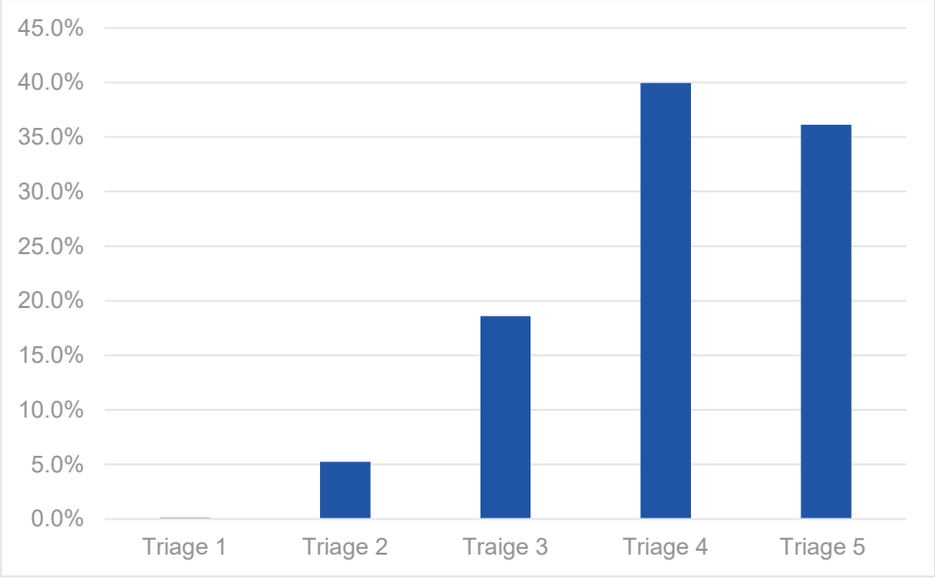
Source: EDAA Version 19

Figure 7 - Total Emergency Presentations by Service Type (Adult / Paediatric), BRDH, 2016 - 2031



The following figure shows that in 2018/19, 39.9 per cent of all emergency presentations were classified as Triage Category 4 presentations, and 36.1 per cent were classified as Triage Category 5 presentations.

Figure 8 – Total Emergency Presentations by Triage Category, BRDH, 2018/19



Other Services

The following table provides details of operating theatre activity at BRDH. The renal dialysis and chemotherapy activity reflects those services provided to Bellingen residents (at a whole of LGA level due to data availability).

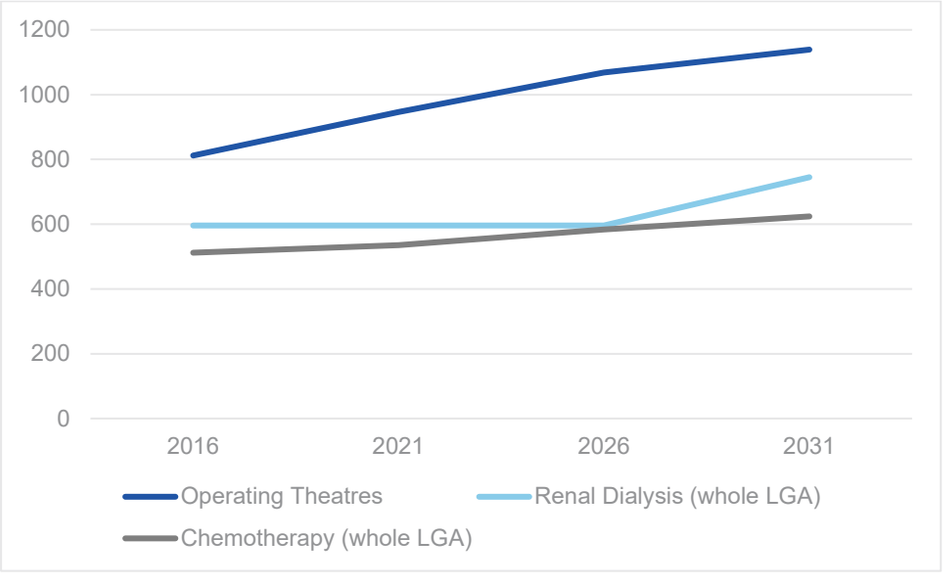
Additional surgical activity analysis is provided in the following section.

Table 14 - Total Service Activity by Service Type (OT, Renal and Chemotherapy), BRDH, 2016 – 2031

	Occasions of Service			
Service Type	2016	2021	2026	2031
Operating Theatres	812	946	1,068	1,139
Renal Dialysis (whole LGA)	596	596	596	745
Chemotherapy (whole LGA)	512	535	584	624

Source: NSW HealthApp

Figure 9 - Total Occasions of Service by Service Type (OT, Renal and Chemotherapy), BRDH, 2016 - 2036



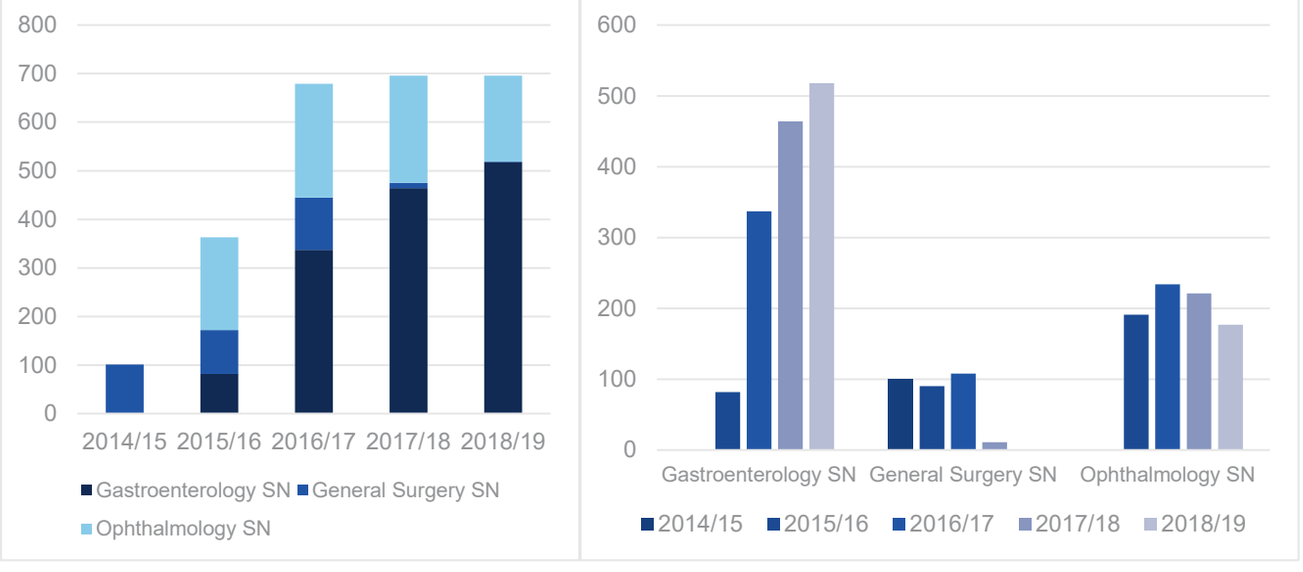
Source: NSW HealthApp

6.3.3 Surgical Activity and Flows

Service Occasions by Specialty, 2014/15 to 2018/19

The following graphs and table provide details of surgical activity at BRDH (derived from Surginet data). BRDH primarily provides gastroenterology (74 per cent of total surgical activity) and ophthalmology services (25 per cent of total surgical activity). General surgical services were provided until 2017/18.

Figure 10 – Total Surgical Service Occasions by Specialty, BRDH, 2014/15 – 2018/19



Source: Surginet

Table 15 - Total Surgical Service Occasions by Specialty, BRDH, 2014/15 – 2018/19

Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	0	82	337	464	518
General Surgery SN	101	90	108	11	1
Ophthalmology SN	0	191	234	221	177
Total	**101**	**363**	**679**	**696**	**696**

Source: Surginet

Service Occasions by Specialty and Age Group, 2014/15 to 2018/19

The following table provides details of surgical activity at BRDH by specialty and age group.

In 2018/19, 49 per cent of total surgical service occasions were provided to patients aged 65+ years, 37 per cent to patients aged 45 – 64 years, and 14 per cent to patients aged 0 – 44 years (noting the absence of capability for paediatric surgery).

Table 16 - Total Surgical Service Occasions by Specialty and Age, BRDH, 2014/15 – 2018/19

Specialty	Age	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	0-44	0	14	52	86	92
	45-64	0	43	152	192	217
	65+	0	25	133	186	209
General Surgery SN	0-44	41	24	27	3	1
	45-64	23	33	50	4	0
	65+	37	33	31	4	0
Ophthalmology SN	0-44	0	2	2	1	4
	45-64	0	35	49	49	41
	65+	0	154	183	171	132
Total	**All ages**	**101**	**363**	**679**	**696**	**696**

Source: Surginet

Service Duration (minutes) by Specialty, 2014/15 to 2018/19

The following table provides details of the total annual minutes for surgical procedures by specialty at BRDH. The average duration of a surgical procedure at BRDH dropped considerably between 2014/15 – 2018/19, from 47.8 minutes to 20.2 minutes.

Table 17 - Total Annual Minutes for Surgical Procedures by Specialty, BRDH, 2014/15 – 2018/19

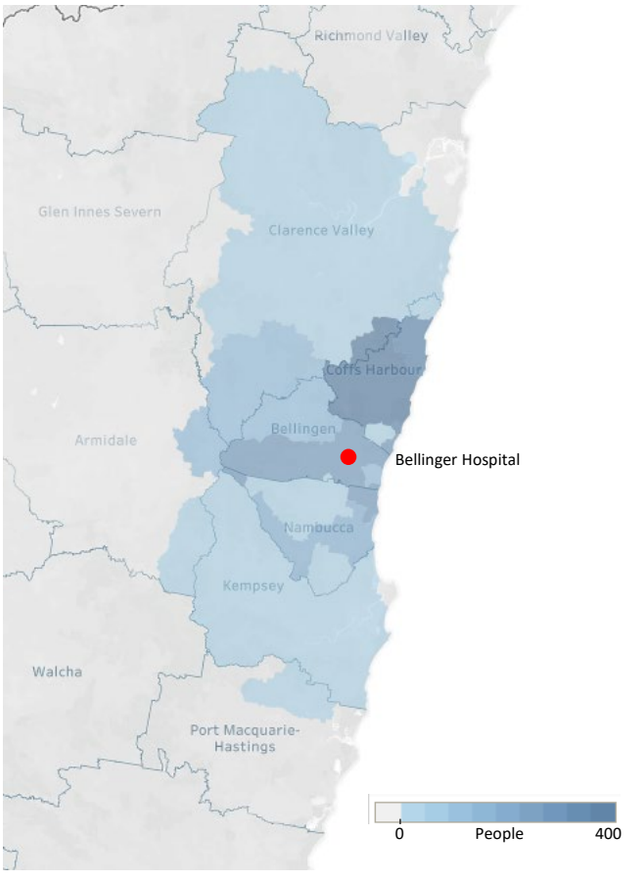
Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	0	2,019	8,299	11,056	10,552
General Surgery SN	4,831	3,710	5,214	517	117
Ophthalmology SN	0	3,555	4,072	4,370	3,395
Total Minutes	4,831	9,284	17,585	15,943	14,064
Average duration	**47.8**	**25.6**	**25.9**	**22.9**	**20.2**

Source: Surginet

Service Occasions by LGA of Residence and Specialty, 2014/15 to 2018/19

The following figure and table provide details of where patients come from to attend BRDH for surgical procedures.

Figure 11 - Total Surgical Service Occasions by Post Code of Residence, BRDH, 2014/15 – 2018/19



Patients at BRDH primarily reside in the immediate surrounding LGAs of Bellingen and Coffs Harbour (note that the figure displays this data by post code, not LGA).

In 2018/19 of total surgical service occasions of service provided at BRDH:

- 58.5 per cent resided in the Coffs Harbour LGA
- 20.3 per cent resided in the Bellingen LGA
- 17% per cent resided in the Nambucca LGA.

Table 18 - Total Surgical Service Occasions by LGA of Residence and Specialty, BRDH, 2014/15 – 2018/19

LGA	Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Bellingen	Gastroenterology SN	0	15	71	95	110
	General Surgery SN	22	14	22	3	
	Ophthalmology SN	0	38	37	39	31
Bellingen Total		22	67	130	137	141
Coffs Harbour	Gastroenterology SN	0	47	160	236	282
	General Surgery SN	49	43	64	2	0
	Oncology SN	0		1	0	0
	Ophthalmology SN		136	168	162	125
Coffs Harbour Total		49	226	393	400	407
Kempsey	Gastroenterology SN	0	0	2	1	1
	General Surgery SN	1	0	1	0	0
	Ophthalmology SN	0	1	1	1	1
Kempsey Total		1	1	4	2	2
Port Macquarie	Gastroenterology SN	0	3	5	11	17
	General Surgery SN	1	1	0	1	0
	Ophthalmology SN	0	0	1	0	1
Port Macquarie Total		1	4	6	12	18
Nambucca	Gastroenterology SN	0	14	81	103	100
	General Surgery SN	23	26	12	5	1
	Ophthalmology SN	0	11	15	11	17
Nambucca Total		23	51	108	119	118
Out of LHD	Gastroenterology SN	0	3	18	18	8
	General Surgery SN	5	6	8	0	0
	Ophthalmology SN	0	5	12	8	2
Out of LHD Total		5	14	38	26	10
Total		**101**	**363**	**679**	**696**	**696**

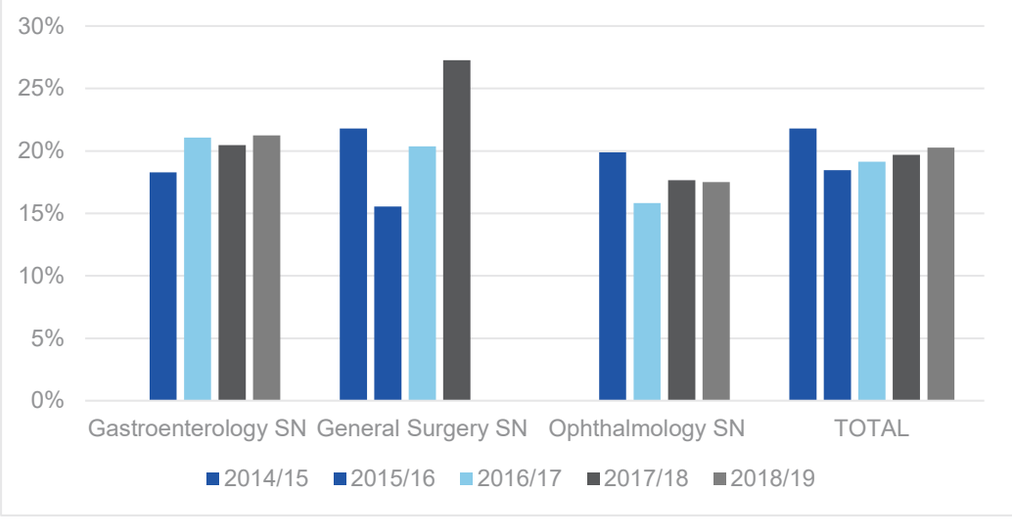
Source: Surginet

Percentage of Service Occasions from Bellingen LGA Residents by Specialty, 2014/15 to 2018/19

The following figure and table provide details on the proportion of patients receiving surgical services at BRDH that reside in the catchment LGA of Bellingen.

In 2018/19, 21 per cent of Bellingen LGA residents who received Gastroenterology services were provided those services from BRDH, and 18 per cent of Bellingen LGA residents who received Ophthalmology services were provided those services from BRDH.

Figure 12 - Total Surgical Service Occasions, Bellingen LGA Residents, by Specialty, BRDH, 2014/15 – 2018/19



Source: Surginet

Table 19 - Total Surgical Service Occasions, Bellingen LGA Residents, by Specialty, BRDH, 2014/15 – 2018/19

Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	n/a	18%	21%	20%	21%
General Surgery SN	22%	16%	20%	27%	0%
Ophthalmology SN	n/a	20%	16%	18%	18%
Total	**22%**	**18%**	**19%**	**20%**	**20%**

Source: Surginet

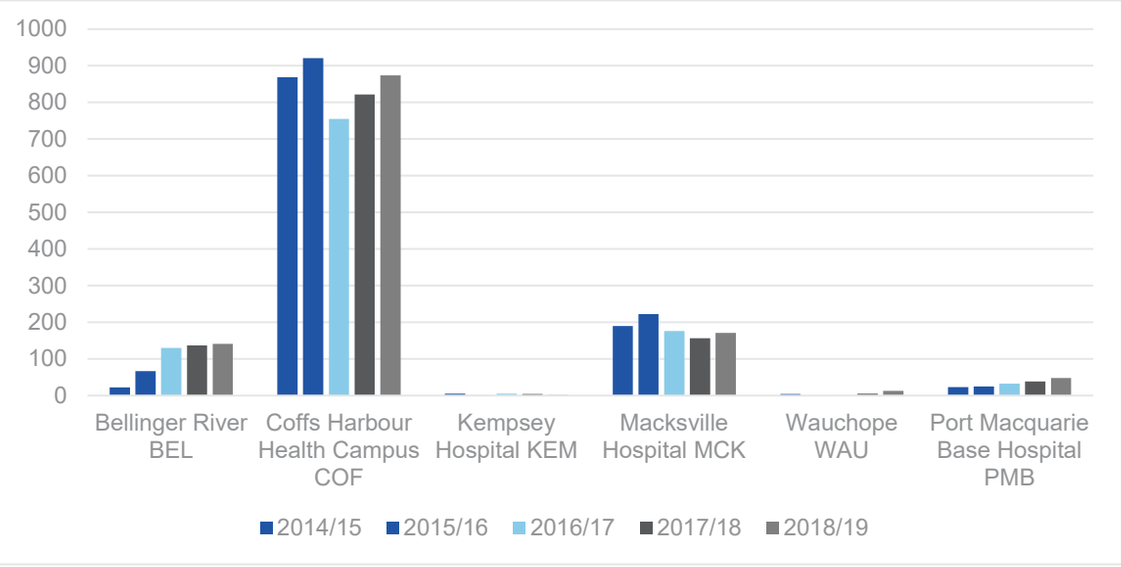
Service Occasions for Residents of Bellingen LGA by MNCLHD Facility Attended, 2014/15 to 2018/19

The following figure and table provide details on which MNCLHD facilities were attended by residents of Bellingen LGA for surgical services.

In 2018/19:

- 70 per cent of Bellingen LGA residents received their surgical service from Coffs Harbour Health Campus
- 14 per cent of Bellingen LGA residents received their surgical service from Macksville Hospital
- 11 per cent of Bellingen LGA residents received their surgical service from BRDH.

Figure 13 - Total Surgical Service Occasions, Bellingen LGA Residents, by Specialty and Facility of Treatment, 2014/15 – 2018/19



Source: Surginet

Table 20 - Total Surgical Service Occasions, Bellingen LGA Residents, by Specialty and Facility of Treatment, 2014/15 – 2018/19

Facility	2014/15	2015/16	2016/17	2017/18	2018/19
Bellinger River	22	67	130	137	141
Coffs Harbour Health Campus	869	921	755	822	874
Kempsey Hospital	5	1	5	4	2
Macksville Hospital	190	222	176	157	171
Wauchope	4		1	5	13
Port Macquarie Base Hospital	23	25	33	39	48
Total	1,113	1,236	1,100	1,164	1,249
Proportion attending BRDH	**2%**	**5%**	**12%**	**12%**	**11%**

Source: Surginet

6.3.4 Outpatient and Non-Admitted Activity

The following table provides a summary of outpatient occasions of service at BRDH, with projections through to 2036. The largest volume of services is for Primary Health Care, which accounted for 47 per cent of total activity in 2018/19. Service activity is projected to increase from 5,600 occasions of service in 2018/19 to 17,417 occasions in 2031/32, at an average AGR of 11.5 per cent.

Patient flows for residents of Bellingen LGA attending outpatient appointments across MNCLHD are provided in Appendix C –. Of the 30,002 outpatient OOS for Bellingen LGA residents in 2018/19, 6,239 were provided at Bellingen facilities (21 per cent self-sufficiency), with 62 per cent provided at Coffs Harbour facilities.

Aggregated Services	2016/17 Activity	2017/18 Activity	2018/19 Activity	2021/22 Activity	2026/27 Activity	2031/32 Activity
Primary Health Care	2,301	2,582	2,615	3,397.7	5,256.8	8,133.1
Wound Management	1,579	2,416	2,296	2,983.3	4,615.6	7,141.0
Allied Health / Other	823	720	689	895.2	1,385.1	2,142.9
Total	**4,703**	**5,718**	**5,600**	**7,276.2**	**11,257.5**	**17,417.0**

6.4 Current Workforce Profile

BRDH uses an average of 84.54 Full Time Equivalent (FTE) per fortnight, across a range of clinical and non-clinical professions / disciplines. The predominant workforce is nursing (67 per cent of total average workforce) followed by Hotel Services staff (13 per cent of total average workforce).

Table 21 – Total Average FTE Used Per Fortnight by Award Code, BRDH, 2019/20

Award Codes	Total FTE	% Total
Nursing	56.88	67%
Hotel Services	10.87	13%
Allied Health	7.26	9%
Corporate & Hospital Support	6.15	7%
Medical (excluding VMOs)	2.88	3%
Scientific & Technical	0.50	1%
Total Average FTE used per fortnight	**84.54**	**100%**

Source: MNCLHD

6.5 Current and Projected Infrastructure

The following projected infrastructure table is calculated on the basis of continued service provision over the timeframe ‘as is’ – that is, without any changes to the service profile or models of care at BRDH.

Table 22 - Projected Infrastructure by Service Type, BRDH, 2021 - 2031

Service Type	Current	2021	2026	2031
ED spaces	3	1.3	1.3	1.3
Isolation	1	0.5	0.5	0.5
Resus bays	1	0.3	0.3	0.3

Total ED Spaces	5	2.1	2.1	2.1
Adult ON Surgical	0	0.2	0.2	0.2
Adult ON Medical	27	11.7	12.9	14.0
Subacute	12	14.7	16.6	17.5
Total ON	39	12.0	13.1	14.2
Same Day	0	0.6	0.6	0.7
Total	0	27.2	30.3	32.3
Operating Theatres	1	0.1	0.1	0.1
Renal Dialysis (whole LGA)	0	1.9	1.9	2.4
Chemotherapy (whole LGA)	0	0.8	0.8	0.9
Outpatient Clinic Space	4	3.0	4.6	7.1

6.6 Future Models of Care and Clinical Service Profiles

The MNCLHD has several initiatives in early stages that will impact future models of care, and potentially clinical service profiles, for Bellingen residents:

- The PACER Project - PACER is a Police and mental health service response activated by Police, offering on-scene and telephone assistance in the community. This pilot project will be implemented across the MNCLHD.
- MNCLHD Virtual Care Project Team are currently canvassing opportunities across the District to virtually link services across the whole district (not just within the clinical network). Various models for both inpatient and outpatient services are being considered, along with soft and hard infrastructure requirements.
- The MNCLD Clinical Service Plan 2018 – 2022 discusses a strategy to redesign how the LHD works with key partners (e.g. GPs) including sharing of information to facilitate the provision of patient centred care.

7. Consultation Process and Outcomes

Stakeholder mapping was undertaken by local MNCLHD staff, and on the 14th and 15th of September 2020, face to face consultations were held at BRDH. Additional stakeholders nominated by those who attended on the aforementioned dates, along with those who were unavailable at that time, were consulted over the phone and virtually in the weeks following. A full list of community and other service providers consulted is at Appendix B – List of Stakeholders Consulted.

MNCLHD staff consultation was undertaken remotely between the 27th and 30th of October.

7.1 Common Themes and Matters Raised

7.1.1 Services lack connectivity

A lack of connectivity between service providers was consistently raised by stakeholders. While stakeholders discussed a sense that the community is well serviced (with some notable exceptions identified within Section 7.3 below), a lack of connectivity between providers of health and social care services was raised, resulting in 'episodic' and 'transactional' care for some providers, that is frequently duplicative, inefficient, and "frustrating for all concerned". Some specific examples provided were:

> *"It's the bits in-between or the things around the edges that need to be looked at. The care at the hospital is done well. Care at the GPs is done well. The school does a great job. But once their bit is done, they wait until their bit needs doing again and don't invest any further".* Bellingen community stakeholder

- GPs discussed a lack of case conferencing with community (LHD) nursing services, stating "I refer to them, I don't get updates (if it's in their brief they don't do it, maybe they don't have time). We're not working well together, we could be doing a lot better".
- As first responders who are increasingly responding to matters relating to social problems (rather than health issues), NSW Ambulance discussed being a rich source of information about individuals within the community who might be in need to connect with community and social supports. While Ambulance officers are excellent clinically, having a comprehensive awareness of locally available services is more difficult – "A good service directory that we can give to people would be great".

7.1.2 Patients have difficulty navigating systems

Navigating a complex system was also consistently raised as something impacting access to services, in two ways:

- Stakeholders don't know all the services that are available to them
- Stakeholders found it difficult to access these services.

The National Disability Insurance Scheme, and My Aged Care were frequently identified by stakeholders as difficult to navigate, particularly for those who do not have support (such as a family or carer, or an advocate).

For local NDIS and other non-Government service providers, and for the local Neighbourhood Centre, offering 'navigation support' services has become part of their role.

Hospital staff discussed that providing support to inpatients to navigate the system is now frequently part of their role. For those patients without an advocate, this includes introducing patients to and supporting them to navigate funding portals including My Aged Care. For complex patients, discharge planning also becomes more complex and time consuming.

> *"Navigating the My Aged Care website without family supports, particularly if they're not computer literature is hopeless. I can spend hours going through this with people. Even I find it hard and we're dealing with people with diminished capacity. It's OK if you've got children who can support you, but some don't. It's not a quick or an easy process."* Bellingen stakeholder

> *"We have a multicategory class with high needs kids and only one of these kids has a NDIS plan, and the parents don't know anything about it, so there's a gap in what they can and can't access. A former P&C President used to run sessions for parents to know what's available and how to access so people would go to her for answers."* Bellingen stakeholder

7.1.3 System integration is difficult

Stakeholders discussed difficulties associated with the ability to easily link systems, share information and data to support integrated and connected care.

For example, NSW Ambulance discussed aged care support, and the role that they are increasingly playing in identifying elderly at risk. In responding to calls, they are one of few health services that will enter a home and be privy to how a person is actually living – "the house won't be tidied by the relatives who come over before the ACAT gets there, we see it as it is". With this in mind, Ambulance are pushing education with staff to look for red flags, to undertake falls and other risk assessments while onsite, however there is a lack of connectivity between providers that means this information is frequently not used.

> *"We do all of these risk assessments, then we do the letters for the doctor, we leave them with the patient and the patient will leave them in a drawer at home. Electronic records are needed, our systems don't talk to any health records, we print things and we hand them over".* NSW Ambulance stakeholder

Notably, the MNCLD Clinical Service Plan 2018 – 2022 discusses a strategy to redesign how the LHD works with key partners (e.g. GPs) including sharing of information to facilitate the provision of patient centred care.

7.1.4 The impact of COVID-19

Stakeholders discussed the impact of COVID-19 as affecting the health of the community in many ways. Mental wellbeing was raised as being impacted by increased social isolation, the cancellation of social events, groups and programs, and increased anxiety associated with uncertainty and disruption to daily activities and routines.

Demand for certain services, such as meals on wheels has significantly increased ("we used to do 200 – 300 meals a month, this has gone to over 1000 per week since COVID").

Volunteers are an important component of service delivery for many organisations providing health and social care services. Stakeholders discussed the impact of COVID-19 creating difficulties in this space with many of the volunteers falling into high risk groups.

> *"It just feels like we don't live at the moment, we just exist, so many people are isolated, the elderly can't have their craft groups, bingo, or day clubs. I feel the most for the elderly people but I know the teenagers are suffering too"*. Bellingen community stakeholder

7.1.5 Understanding social factors at play

Emphasising wellness and holistic care

Bellingen stakeholders were clear in their description of health as also encompassing 'wellness', involving physical, mental and social well-being. Similarly, community service providers communicated their view that healthcare is more than those services provided from the hospital or the General Practice clinic. A broader perspective was emphasised, involving a healthy lifestyle and the building of healthy and supportive relationships and connections within the community.

> *"There is a real sense of community in this town, as people are sharing information and collaborating. There's a desire for holistic care – body, mind, spirit – it's about wellbeing."* Bellingen community stakeholder

Housing affordability and homelessness in Bellingen

Several stakeholders made the point that property prices in Bellingen are high, having been driven up by an influx of people moving into the area. Community / affordable housing options are limited, compounded by the closing down of a 39-bed hostel in Watson Street which 'wasn't about people who needed care, but needed a place to stay'. Private rental properties are both expensive and limited due to people preferring to 'holiday let' their homes.

Consequently, homelessness was raised as an issue by Bellingen community stakeholders. From an aged care perspective, nursing home representatives reported that they are 'never without' requests for admission from people who are living in their cars or couch surfing. Individuals working with youth also raised concerns.

Considering the impact of low immunisation rates

Stakeholders discussed the attraction of many to the less mainstream elements of the Bellingen community, including those electing not to vaccinate their children. As evidence suggests, vaccination reduces hospitalisations and deaths, especially in the most vulnerable (the very young and very old). Between 1 July 2018 to 30 June 2019, across NSW, 94% of children were fully immunised at one year of age, however in Bellingen LGA, this number was 83.7%.[8]

Additional to health consequences, social consequences raised by stakeholders include the preclusion of unvaccinated children from government funded daycare

> *"We all know early intervention for child development is best, and we're trained look for these things and encourage parents to access the support they need. If they're not here, who does this? Waiting until school age for a problem to be picked up isn't ideal."* Bellingen community stakeholder

[8] Data Source: Australian Immunisation Register, available at: https://www.health.nsw.gov.au/immunisation/Pages/lga-by-lhd-latest-quarter.aspx#bookmark5

options and approved kindergarten programs (that support children's participation in quality early childhood education).

Understanding and accommodating the needs of the broader region

Stakeholders were clear in the need to consider the individual needs of communities within the broader region, and also the particular difficulties associated with operating in a regional / rural area.

Some stakeholders discussed the difficulties in providing services to individuals who live great distances from service providers, particularly for those services operating on a 'for fee' basis, where hours of unfunded travel was discussed as 'unsustainable'.

7.1.6 Staff recruitment and retention

Issues in recruiting and retaining a competent health workforce, and maintaining workforce skills through access to training opportunities was raised by stakeholders. Several groups discussed extended vacancies as driving limited services.

Stakeholders noted the ability to access services virtually still requires local clinical support, however participation in virtual care is an upskilling opportunity for local staff members.

7.2 Service Gaps / Opportunities for Development

7.2.1 Mental health services

Stakeholders discussed the need for mental health services as a huge concern affecting all age groups, from child and youth through to older persons.

Stakeholders also discussed that there are services available to the community, delivered by a 'plethora of different agencies', but that not everybody knows what is available or how to connect to it. Many services are restricted by funding guidelines, "we do this, but we're not funded to do that", and this makes referrals and connecting care across providers more difficult, particularly when "policy and guidelines are changing all the time, and providers are competing for funds".

> *"We've had drought, bushfire recovery, COVID and Christmas is coming. Mental health is a huge issue from the young through to the old."* Bellingen community stakeholder

Staff nominated a gap in the provision of mental health services for Bellingen Hospital inpatients (mental health services are currently only provided to outpatients).

7.2.2 Lack of local public allied health services, including for early intervention

Stakeholders nominated local access to public allied health services as a gap for the community, discussing extended waiting for these services to be accessed from Coffs Harbour. Allied health staff noted that due to demand there is a need to focus on inpatient care at the hospital, and that these services have been placed increasingly under pressure over time due to an increasingly complex patient caseload and needing to take on more administrative tasks including discharge planning and transport coordination. Also, physiotherapy staff identified increased length of stay associated with a lack of allied health services over the weekend.

> *"Often I'll get a patient back to a good level [of function] on a Friday and on Monday they're back to their Tuesday level."* Bellingen Hospital Physiotherapist

Hospital physiotherapists are well connected with local general practitioners, receiving referrals from surgeries via email. Due to COVID, a local fracture clinic has commenced, telelinked to orthopaedics in Coffs Harbour. This has been well received by patients who can now access these services locally rather than travel to Coffs Harbour. Previously, physiotherapists provided a community-based falls prevention program ('Stepping On'), however this service is no longer resourced.

While outpatient psychology services are provided including through telehealth, a key gap identified was the provision of these services to inpatients.

The importance of ready access was highlighted with regard to early intervention models, which by definition require ready support within a nominated timeframe. While positive relationships exist between local private allied health providers and education providers, including for speech pathology and occupational therapy, these services are paid for with NDIS funding, which is only accessible following an assessment and diagnosis from a paediatrician (and this a key gap, see 'Access to specialist services' below). Waiting times for public paediatric allied health services, available from Coffs Harbour (not locally), was identified as significant.

The key early intervention gap from the perspective of education sector stakeholders is mental health, who discussed a need to "whittle down a list of 100 kids to eight kids for the 'Getting On Track In Time – Got It!" program"[9]. Oral health was also nominated as not having visited the local public schools for an extended period.

7.2.3 Access to specialist services

While most stakeholders accepted that the majority of specialist services could not be provided locally, timely access to public specialist outpatient services was identified as a gap for the local community. Extended waits for services from Coffs Harbour were discussed.

Importantly, almost all stakeholders spoke positively about their experiences with virtual care and telehealth, and considered this to be a viable option for accessing specialist services locally if local infrastructure to support these models was available.

Staff noted a need to address inpatients who require specialist input such as psychiatry or geriatrics – "a mental health consult liaison and link up with a psychiatrist would be good".

7.2.4 Health promotion

In acknowledgement of difficulties navigating systems, and identifying a gap in the provision of health promotion services, community stakeholders are keen to step into a role that supports health and health service promotion. One stakeholder had commenced planning for a 'health and wellness expo' to bring together health and wellness service providers, however planning was halted due to COVID. The aim of the expo was to support connections between providers and to promote services available to the community.

Another stakeholder was keen to use their social media platform to communicate and provide regular health promotion information to the community, with MNCLHD providers of these services noting that their work is focused on NSW Ministry of Health priorities, such as healthy eating and active living.

7.2.5 Closing the Gap – Focusing on Aboriginal Health

All stakeholders were keen to ensure that service planning consider strategies to improve health outcomes for the local Aboriginal population, and continue to take action in order to achieve progress in Closing the Gap in health outcomes for Aboriginal people.

Stakeholders discussed a multi-faceted approach as being required, thinking through all the factors that impact socioeconomic disadvantage and health outcomes, including opportunities to work, access to transport and education level.

[9] *Got It!* teams deliver specialist mental health early intervention services for children in Kindergarten to Year 2 (K-2) aged 5-8 years old, who display behavioural concerns and emerging conduct problems.

Aboriginal health representatives discussed access to drug and alcohol, mental health services and early intervention models (including support for parents and families) as key priorities, along with culturally appropriate transport options which provide greater capacity for family travel. Services that support community members to take responsibility for their health (health education and promotion) were also identified as a need. Collaborations with Aboriginal Medical Services are being pursued along with the Primary Healthcare Network.

Models of care that promote cultural safety and security were emphasised by stakeholders, such as care in the home supported by an Aboriginal Liaison Officer. Stakeholders noted telehealth / virtual care models have been well received by the Aboriginal community, but a need to remember that 'social disadvantage means that I may not have a phone, or internet'.

> *"It would be really beneficial to have a cultural room or cultural centre at Bellingen Hospital, to enable culture conversations with a patient to continue. A more supportive environment to breakaway."*
> Aboriginal Health representative

7.2.6 Access to non-emergency transport

Consistent feedback was provided from stakeholders in relation to difficulties accessing transport. This feedback covered a range of providers including public transport, taxis and other for-profit providers such as The Community Transport Company, along with patient transport services which are brokered by MNCLHD Health Transport Unit.

In part, stakeholders discussed a lack of access as relating to the need to meet eligibility criteria, and to access funding for transport through the NDIS, along with service providers scheduling services and programs at peak times – "Greater communication between transport and care providers would be great".

Capacity issues were also nominated by stakeholders providing transport services for the elderly, disabled and those requiring assistance with travel ("people who can't get public transport"). This is compounded by local taxis being expensive and public transport only available in a very limited fashion.

Across the MNCLHD, transport services are brokered but coordinated through a transport hub. One factor raised as contributing to delays in accessing transport (and extended bed stays) was a lack of discharge planning that involves early consideration (and notification to the transport hub) of patient transport needs. Late notification means that patients may not arrive until later in the day, when there may not be medical coverage (which is unacceptable).

8. Strategies for Future Development / Change

In accordance with the planning approach, strategies for future development and change are intended to adopt a holistic approach to addressing the health needs of the Bellingen community and involve partners in solutions.

Establishing, or participating in, a forum for service provider networking

1. A representative from Bellingen Health Services should coordinate or attend an established forum for service provider networking. The goal of this activity is to improve the understanding of services available to the community, and the manner in which MNCLHD services connect with these services. The interagency meeting hosted by the Bellingen Neighbourhood Centre (occurring every second month) should be canvassed for suitability.

2. Identify other ways to increase the awareness of service providers operating locally, for example, GPs opening their rooms to service providers for an evening (involving the Primary Healthcare Network).

3. As precedence exists in other jurisdictions, ascertain the potential for joint funding for a community service provider liaison role, to support the forum and facilitate networking between health and social service providers operating in the community.

Harnessing 'system navigators' to address access inequity

4. Through the provider forum, map those local providers who offer 'system navigators' (e.g. providing support for people to navigate the NDIS and My Aged Care portals), and establish a way to identify and connect community members with these services. Examples might include accepting referrals from education providers to educate and support parents through the NDIS, or in-reach to hospital patients who require support for My Aged Care. Consideration should be given to 'taking these services to the community', identifying areas of high need and finding ways to connect.

Supporting community wellness through early intervention and hospital avoidance

5. Improve the use of information from other service providers operating within the system, including paramedics providing unscheduled primary health care, and support the correct direction of this information for use by other providers within the system.

6. Increase local access to public allied health services, including those for paediatric patients.

Focusing on mental health

7. Map all providers of mental health and wellbeing services within the area, and seek to identify exactly what they provide (and to whom) and how their services are accessed. The goal of this activity is to increase understanding and connectivity between providers with a view to supporting patient access to the right care at the right time.

Supporting community involvement in health and health service promotion

8. Canvass community and social service providers who may be able to support the local dissemination of health promotion information and coordination of health promotion activities for the community. For example, Rotary, who was planning a 'health expo', expressed a keenness to take a role in health promotion (including through social media), and the neighbourhood centre provide updates to a local business and community service directory hosted by the council (https://ilovebelloshire.com/).

9. Consider the ability of the local health promotion group to support the MNCLHD Public Health Unit in relation to the provision of information to the local community about immunisation and the NSW Immunisation Program.

Accessing available infrastructure, looking for opportunities to collocate services

10. Seek to identify suitable locations within the community to collocate health services with social and community services. Examples may include libraries (for navigator services), neighbourhood centres, cross-jurisdiction service providers (for example employment agencies), NGO health service partners and/or providers of other social services.

Greater support for discharge planning and community service provider liaison

11. Increase resources for discharge planning from BRDH to enable improved flow of patients across the system, and support these resources to maintain their awareness of local community service programs and providers, to enable patients to receive optimal care in the right place.

Improve access to non-emergency patient transport

12. Support the early identification of patient transport needs through discharge planning.
13. Advocate on behalf of Health to Transport NSW, for transport solutions linking point to point providers with nominated / scheduled public transport routes. This will require strong engagement with community for-profit transport providers.

Enabling better integration between MNCLHD services and improved local service access

14. Enhance the network patient flow model across MNCLHD, working as a hub with transport and smaller sites.
15. Engage with MNCLHD Virtual Care Project Team regarding increasing local access to:
    a. Public allied health services, including those for paediatric patients (outpatient services)
    b. Specialist paediatric outpatient services
    c. Specialist psychiatry outpatient services
    d. Inpatient specialist services, including psychiatry and geriatrics.
16. Review technical and infrastructure enablers and local support requirements to ensure appropriate implementation of virtual models of care.

Focusing on Aboriginal Health

17. Create a culturally safe space within BRDH to support Aboriginal patient and family discussions.
18. Ensure all health and health promotion activities consider the most effective and culturally appropriate manner for communicating with Aboriginal people.

Addressing homelessness in Bellingen

19. Advocate on behalf of Health for more affordable housing within Bellingen, including to the Bellingen Shire Council who recognises this issue and is working towards improving and addressing this issue through land use planning.

9. Implementation Approach

The following action plan has been developed, identifying dependencies and timelines, to support the implementation of the strategies for future development / change. The responsibility for implementing the actions, along with reporting on the progress of implementation (governance), will be identified by Mid North Coast Local Health District, in accordance with local governance structures, roles and responsibilities.

Action No.	Considerations / Dependencies	Timeline
Establishing, or participating in, a forum for service provider networking		
A representative from Bellingen Health Services should coordinate or attend an established forum for service provider networking. The goal of this activity is to improve the understanding of services available to the community, and the manner in which MNCLHD services connect with these services. The interagency meeting hosted by the Bellingen Neighbourhood Centre (occurring every second month) should be canvassed for suitability.	A forum that is focused on the provision of services locally is required. Initial enquiries about whether such a forum exists, or to seek sponsorship for coordination should be to the local Neighbourhood centre and to the PHN.	ASAP
Identify other ways to increase the awareness of service providers operating locally, for example, GPs opening their rooms to service providers for an evening (involving the Primary Healthcare Network).	This should occur through the service provider forum to ensure broad participation. Ideally the PHN would coordinate this activity.	6 – 12 months
As precedence exists in other jurisdictions, ascertain the potential for joint funding for a community service provider liaison role, to support the forum and facilitate networking between health and social service providers operating in the community.		ASAP
Harnessing 'system navigators' to address access inequity		
Through the provider forum, map those local providers who offer 'system navigators' (e.g. providing support for people to navigate the NDIS and My Aged Care portals), and establish a way to identify and connect community members with these services. Examples might include accepting referrals from education providers to educate and support parents through the NDIS, or in-reach to hospital patients who require support for My Aged Care.	This should occur through the service provider forum.	6 – 12 months

Consideration should be given to 'taking these services to the community', identifying areas of high need and finding ways to connect.		
Supporting community wellness, early intervention and hospital avoidance		
Improve the use of information from other service providers operating within the system, including paramedics providing unscheduled primary health care, and support the correct direction of this information for use by other providers within the system.	This should occur after the establishment of, or through the service provider forum, which would ideally include NSW Ambulance. Very simply, the type of information collected should be identified first, then who would be interested in accessing this information, then how they should receive it.	12 – 24 months
Increase local access to public allied health services, including those for paediatric patients.	This should be for the consideration of MNCLHD Executive. Impediments to this, such as the availability and suitability of local infrastructure, along with workforce considerations, will need to be examined.	12 – 24 months
Focusing on mental health		
Map all providers of mental health and wellbeing services within the area, and seek to identify exactly what they provide (and to whom) and how their services are accessed. The goal of this activity is to increase understanding and connectivity between providers with a view to supporting patient access to the right care at the right time.	This should occur through the service provider forum.	6 – 12 months
Supporting community involvement in health and health service promotion		
Canvass community and social service providers who may be able to support the local dissemination of health promotion information and coordination of health promotion activities for the community. For example, Rotary, who was planning a 'health expo', expressed a keenness to take a role in health promotion (including through social media),	This should occur through the service provider forum, however consideration should be given to social and community groups who wish to take this on (e.g. Rotary, the Neighbourhood Centre, etc.).	6 – 12 months

and the neighbourhood centre provide updates to a local business and community service directory hosted by the council (https://ilovebelloshire.com/).		
Consider the ability of the local health promotion group to support the MNCLHD Public Health Unit in relation to the provision of information to the local community about immunisation and the NSW Immunisation Program.	This would need to occur following the establishment of the local health promotion group	12 – 24 months
Accessing available infrastructure, looking for opportunities to collocate services		
Seek to identify suitable locations within the community to collocate health services with social and community services. Examples may include libraries (for navigator services), neighbourhood centres, cross-jurisdiction service providers (for example employment agencies), NGO health service partners and/or providers of other social services.	This should occur through the service provider forum, however initially those services that health consider suitable for locating away from health campuses should be considered by MNCLHD Executive.	12 – 24 months
Greater support for discharge planning and community service provider liaison services		
Increase resources for discharge planning from BRDH to enable improved flow of patients across the system, and support these resources to maintain their awareness of local community service programs and providers, to enable patients to receive optimal care in the right place.	This should be for the consideration of MNCLHD Executive.	6 – 12 months
Improve access to non-emergency patient transport		
Support the early identification of patient transport needs through discharge planning.	This should be for the consideration of MNCLHD Executive.	6 – 12 months
Advocate on behalf of Health to Transport NSW, for transport solutions linking point to point providers with nominated / scheduled public transport routes. This will require strong engagement with community for-profit transport providers.	This should be for the consideration of MNCLHD Executive, who may advocate with NSW Transport for a pilot project.	12 – 24 months
Enabling better integration between MNCLHD services and improved local service access		

Enhance the network patient flow model across MNCLHD, working as a hub with transport and smaller sites.		ASAP
Engage with MNCLHD Virtual Care Project Team regarding increasing local access to: a. Public allied health services, including those for paediatric patients (outpatient services) b. Specialist paediatric outpatient services c. Specialist psychiatry outpatient services d. Inpatient specialist services, including psychiatry and geriatrics.	This should be for the consideration of MNCLHD Executive, and the MNCLHD Virtual Care Project Team.	12 – 24 months
Review technical and infrastructure enablers and local support requirements to ensure appropriate implementation of virtual models of care.	This should be for the consideration of MNCLHD Executive, and the MNCLHD Virtual Care Project Team.	12 – 24 months
Focusing on Aboriginal Health		
Create a culturally safe space within BRDH to support Aboriginal patient and family discussions.	This should be for the consideration of MNCLHD Executive, and included within any infrastructure-focused planning for the site.	As capital funding is available
Ensure all health and health promotion activities consider the most effective and culturally appropriate manner for communicating with Aboriginal people.	As for strategies to support community involvement in health and health service promotion (above), this should occur through the service provider forum and involve MNCLHD Aboriginal Health representatives.	6 – 12 months
Addressing homelessness in Wauchope		
Advocate on behalf of Health for more affordable housing within Bellingen, including to the Bellingen Shire Council who recognises this issue and is working towards improving and addressing this issue through land use planning.	This should be for the consideration of MNCLHD Executive.	ASAP

9.1 Evaluation and Reporting

As previously discussed, the responsibility for implementing the actions, along with reporting on the progress of implementation (governance), will be identified by Mid North Coast Local Health District, in accordance with local governance structures, roles and responsibilities.

A set of indicators will also be developed to measure the impact of adopted strategies.

Appendix A – Role Delineation

Table 23 – Bellingen River District Hospital

Services #	Service Type	Role Level: 2019 Guidelines	Commentary for Change	Page Reference
Core Services				
1	Anaesthesia & Recovery	3		
2	Operating Suite	3		
3	Close Observation	NPS	No Planned Service	15
4	Intensive Care	NPS	No Planned Service	16
5	Nuclear Medicine	4	Networked Service	19
6	Radiology & Interventional Radiology	3		
7	Pathology	3		
8	Pharmacy	3		
Emergency Medicine				
A	Emergency Medicine	3		
Medicine				
B1	Acute Stroke Services (Adult)	NPS		
B2	Cardiology & Interventional Cardiology	2	Provides access at Network level	33
B3	Chronic Pain Management	NPS	No Planned Service	35
B4	Clinical Genetics	NPS	No Planned Service	37
B5	Dermatology	2		
B6	Drug and Alcohol Services	1	Ad-hoc service available	40
B7	Endocrinology	3	See note re COU in appendix 1. Patient selection = low risk, networked processes in place.	
B8	Gastroenterology	3	See note re COU in appendix 1. Patient selection = low risk, networked processes in place.	
B9	General & Acute Medicine	3	See note re COU in appendix 1. Patient selection = low risk, networked processes in place.	

B10	Geriatric Medicine	3		
B11	Haematology	3		
B12	Immunology	NPS	No Planned Service	53
B13	Infectious Diseases	2		
B14	Neurology	3		
B15	Medical Oncology	1		
B16	Radiation Oncology	NPS	No Planned Service	61
B17	Palliative Care	3	Operates at level 3, but without the Core Service of a Close Observation Unit. Note: Patient Selection - only appropriate level ASA patients treated at facility, those not for further intervention Escalation Process - clear process for transferring patients to Coffs Harbour if necessary Is a networked service within the Coffs Clinical Network Staffing can increase to provide closer monitoring	63
B18	Rehabilitation Medicine	3		
B19	Renal Medicine	NPS	No Planned Service	68
B20	Respiratory and Sleep Medicine	2		
B21	Rheumatology	2		
B22	Sexual Assault Services	3		
B23	Sexual Health	1		
Surgery				
C1	Burns	2		
C2	Cardiothoracic Surgery	NPS	No Planned Service	81
C3	ENT Surgery	3	See note re COU in appendix 1. Patient selection = low risk, networked processes in place.	83
C4	General Surgery	2		
C5	Gynaecology	2		
C6	Neurosurgery	NPS	No Planned Service	89

C7	Ophthalmology	3	Operates at level 3, but without the Core Service of a Close Observation Unit. Note: Patient Selection - only appropriate level ASA patients treated at facility, those not for further intervention. Patients are day only. Pre-admission processes in place. Escalation Process - clear process for transferring patients to Coffs Harbour if necessary Is a networked service within the Coffs Clinical Network Staffing can increase to provide closer monitoring	91
C8	Oral Health	NPS	No Planned Service	93
C9	Orthopaedic Surgery	NPS	No Planned Service	95
C10	Plastic Surgery	NPS	No Planned Service	97
C11	Urology	NPS	No Planned Service	99
C12	Vascular Surgery	NPS	No Planned Service	101
Child and Family Health				
D1	Child and Family Health	3		
D2	Child Protection Services	1		
D3	Maternity	NPS	No Planned Service	108
D4	Neonatal	NPS	No Planned Service	111
D5	Paediatric Medicine	2		
D6	Surgery for Children	NPS	No Planned Service	116
D7	Youth Health	NPS	No Planned Service	118
Mental Health				
E1	Adult Mental Health	2		
E2	Child and Youth Mental Health	NPS	No Planned Service	123
E3	Older Person Mental Health	NPS	No Planned Service	126
Aboriginal Health				
F1	Aboriginal Health	4		
Community Health				
G	Community Health	3	Networked Service	133

Appendix B – Steering Committee & Stakeholders Consulted

Table 24 – Project Steering Committee

Name	Position / Organisation
Stewart Dowrick (Chair)	Chief Executive Officer Mid North Coast Local Health District
Tammy Hughes	District Manager, Planning and Service Development Mid North Coast Local Health District
Peter Bereicua	Manager Capital Works and Asset Management Mid North Coast Local Health District
Catharine Death and Theresa Beswick	Network Coordinators and General Managers, Bellingen and Wauchope Health Services
Janine Reed and Neville Parsons	Mid North Coast Local Health District Board Members and Bellingen / Wauchope community members
Dr Philip Ewart	General Practitioner – Hastings Medical

Table 25 – Stakeholders Consulted

Name	Position / Organisation
Sue Beehag	General Manager Bellorana Nursing Home
Dr Gull Herzberg	General Practitioner, Bellingen Healing Centre
Dean Besley	Bellingen Youth Hub Centre Co-ordinator
Anne Goode	Anglican Priest/Chaplain in Bellingen and Chaplain at Coffs Harbour Health Campus
May Smith	Manager, Bellingen Neighbourhood Centre
Clayton Sippel	CEO, Open Arms Incorporated
Marion Campbell	Operations Manager, Community Transport
Kim Dixon	Bellingen High School Principal
Deb Anderson	Chair Hospital Auxiliary/Pink ladies
Barbara Moore	President, Bellingen Health Action Group
Fenella Briscomb	Secretary, Bellingen Health Action Group
Michelle McFadyen	Deputy General Manager, Bellingen Shire Council
Allison Patterson	Manager Community Wellbeing, Bellingen Shire Council
Diane Christian	President, Bellingen Rotary Club

John Alford	Acting Health Relationship Manager, Peer Support Officer, Regional Operations/Mid-North Coast Sector, NSW Ambulance
Miranda Ivanoff	New Graduate, Registered Nurse, Bellingen Hospital
Leonie Adams	Hotel Services Manager, Bellinger River District Hospital
Jennifer Doust	Occupational Therapist, Bellinger River District Hospital
Jenni Gerdes	Clinical Nurse Educator, Bellinger River District Hospital
Ben Watkins	Registered Nurse, Bellinger River District Hospital
Joseph Potts	Physiotherapist, Bellinger River District Hospital
Ray Beaumont	NUM General Ward, Bellinger River District Hospital
Michelle Guest	Registered Nurse, Bellinger River District Hospital
Alanna Thompson	Registered Nurse, Bellinger River District Hospital
Chantel Baker	Acting Deputy Director of Nursing, Bellinger River District Hospital
Jennifer Helisma	Nurse Educator, Bellinger River District Hospital/Macksville Hospital
Ray Green	EO DON, Bellinger River District Hospital
Marisa Horseman	Discharge Planner, Bellinger River District Hospital
Michelle Doenau	Mental Health Worker, Bellinger River District Hospital
Dr Derek Bell	GP / VMO, Bellinger River District Hospital
Dr Olivia Bell	GP / VMO, Bellinger River District Hospital
Maxine Walker	Network Aboriginal Health Manager Mid North Coast Local Health District
Jen Haberecht	Senior Project Officer Rural Recovery Support Service - Northern NSW & Tablelands Engagement & Industry Assistance Department of Primary Industries
Orry Berry	Rural Adversity Mental Health Program Coordinator, Mid North Coast Local Health District
Steve Mann	Director, System and Service Integration, Healthy North Coast (Primary Healthcare Network)
Julie Dodds	District Manager Patient Transport Services, Health Transport Unit Mid North Coast Local Health District
David Noble	District Manager, Community Mental Health Mid North Coast Local Health District
Linda Kay	Health Reform Manager Mid North Coast Local Health District
Lynne Halliday	Nurse Manager Mental Health Inpatient Services Mid North Coast Local Health District
Amy Sawyer	A/Manager Health Promotion Mid North Coast Local Health District

Johannah Alabam	Project Manager Mid North Coast Virtual Care
Anthea Young	A/Project Manager Mid North Coast Virtual Care
Carmel Ireland	District Manager for Oral Health Mid North Coast Local Health District
Naomi Wilson	Primary School Mobile Dental Van Coordinator Mid North Coast Local Health District
Colleen Ryan	Network Manager, Community and Allied Health Mid North Coast Local Health District
Marie Beswick	Manager Aged Care Mid North Coast Local Health District
Tammy Hughes	District Manager, Planning and Service Development Mid North Coast Local Health District
Wendy Munro	Drug and Alcohol services Mid North Coast Local Health District
Kath Brown	A/Director of Mental Health and Integrated Care Mid North Coast Local Health District
Dan Morrison	Executive Network Manager, Aboriginal Health, Hastings Macleay Clinical Network Mid North Coast Local Health District
Ro Stirling-Kelly	Consumer Engagement Coordinator Mid North Coast Local Health District
Joe Bryant	Aboriginal Health Program Coordinator Mid North Coast Local Health District

Appendix C – Outpatient Flows

Residents of Bellingen LGA

Code	Tier 2 Name	Bellingen	Coffs Harbour	Dorrigo	Drugs Alcohol	Kempsey	Macksville	Port Macq.	Wauchope
10.02	Interventional Imaging	0%	100%	0%	0%	0%	0%	0%	0%
10.03	Minor Surgical	100%	0%	0%	0%	0%	0%	0%	0%
10.1	Renal Dialysis - Hospital	0%	0%	0%	0%	0%	100%	0%	0%
10.11	Chemotherapy -	0%	100%	0%	0%	0%	0%	0%	0%
10.12	Radiation Therapy -	0%	97%	0%	0%	0%	0%	3%	0%
10.13	Minor Medical	0%	89%	0%	0%	0%	5%	5%	0%
10.14	Pain Management	0%	100%	0%	0%	0%	0%	0%	0%
10.18	Enteral Nutrition -	0%	100%	0%	0%	0%	0%	0%	0%
10.2	Radiation Therapy -	0%	97%	0%	0%	0%	0%	3%	0%
20.02	Anaesthetics	0%	0%	0%	0%	0%	0%	100%	0%
20.03	Pain Management	0%	100%	0%	0%	0%	0%	0%	0%
20.05	General Medicine	0%	63%	0%	0%	0%	0%	0%	38%
20.08	Genetics	0%	100%	0%	0%	0%	0%	0%	0%
20.09	Geriatric Medicine	0%	100%	0%	0%	0%	0%	0%	0%
20.13	Palliative Care	0%	100%	0%	0%	0%	0%	0%	0%
20.24	Vascular Surgery	0%	0%	0%	0%	100%	0%	0%	0%
20.25	Gastroenterology	0%	100%	0%	0%	0%	0%	0%	0%
20.26	Hepatobiliary	0%	100%	0%	0%	0%	0%	0%	0%
20.28	Metabolic Bone	0%	100%	0%	0%	0%	0%	0%	0%
20.29	Orthopaedics	0%	100%	0%	0%	0%	0%	0%	0%
20.34	Endocrinology	0%	100%	0%	0%	0%	0%	0%	0%
20.35	Nephrology	0%	100%	0%	0%	0%	0%	0%	0%
20.38	Gynaecology	0%	100%	0%	0%	0%	0%	0%	0%
20.42	Medical Oncology	0%	100%	0%	0%	0%	0%	0%	0%
20.43	Radiation Oncology	0%	98%	0%	0%	0%	0%	2%	0%
20.44	Infectious Diseases	0%	99%	0%	0%	0%	0%	1%	0%
20.47	Rehabilitation	0%	100%	0%	0%	0%	0%	0%	0%

20.5	Psychogeriatric	0%	100%	0%	0%	0%	0%	0%	0%
20.52	Addiction Medicine	0%	0%	0%	100%	0%	0%	0%	0%
30.01	General Imaging	32%	68%	0%	0%	0%	0%	0%	0%
40.02	Aged Care Assessment	0%	100%	0%	0%	0%	0%	0%	0%
40.05	Hydrotherapy	0%	100%	0%	0%	0%	0%	0%	0%
40.06	Occupational Therapy	24%	7%	69%	0%	0%	0%	0%	0%
40.07	Pre-Admission and Pre-	0%	93%	0%	0%	0%	1%	6%	0%
40.08	Primary Health Care	54%	13%	13%	0%	0%	20%	0%	0%
40.09	Physiotherapy	22%	16%	62%	0%	0%	0%	0%	0%
40.1	Sexual Health	0%	100%	0%	0%	0%	0%	0%	0%
40.11	Social Work	36%	64%	0%	0%	0%	0%	0%	0%
40.12	Rehabilitation	0%	83%	0%	0%	0%	17%	0%	0%
40.13	Wound Management	57%	3%	39%	0%	0%	2%	0%	0%
40.14	Neuropsychology	0%	100%	0%	0%	0%	0%	0%	0%
40.17	Audiology	0%	100%	0%	0%	0%	0%	0%	0%
40.18	Speech Pathology	0%	98%	0%	0%	0%	2%	0%	0%
40.21	Cardiac Rehabilitation	0%	54%	0%	0%	0%	46%	0%	0%
40.22	Stomal Therapy	0%	100%	0%	0%	0%	0%	0%	0%
40.23	Nutrition/Dietetics	0%	100%	0%	0%	0%	0%	0%	0%
40.25	Podiatry	0%	100%	0%	0%	0%	0%	0%	0%
40.27	Family Planning	0%	0%	0%	0%	0%	0%	100%	0%
40.28	Midwifery and	0%	98%	0%	0%	0%	2%	0%	0%
40.3	Alcohol and Other	0%	0%	0%	100%	0%	0%	0%	0%
40.32	Continence	0%	100%	0%	0%	0%	0%	0%	0%
40.34	Specialist Mental	50%	50%	0%	0%	0%	0%	0%	0%
40.35	Palliative Care	0%	40%	20%	0%	0%	40%	0%	0%
40.37	Psychogeriatric	0%	100%	0%	0%	0%	0%	0%	0%
40.38	Infectious Diseases	0%	100%	0%	0%	0%	0%	0%	0%
40.42	Circulatory	0%	100%	0%	0%	0%	0%	0%	0%
40.43	Hepatobiliary	0%	90%	0%	0%	0%	0%	10%	0%
40.44	Orthopaedics	0%	100%	0%	0%	0%	0%	0%	0%
40.46	Endocrinology	0%	100%	0%	0%	0%	0%	0%	0%

40.47	Nephrology	0%	100%	0%	0%	0%	0%	0%	0%
40.51	Breast	0%	96%	0%	0%	0%	0%	4%	0%
40.52	Oncology	0%	98%	0%	0%	0%	0%	2%	0%
40.55	Paediatrics	0%	100%	0%	0%	0%	0%	0%	0%
40.56	Falls Prevention	0%	100%	0%	0%	0%	0%	0%	0%
40.58	Hospital Avoidance	0%	100%	0%	0%	0%	0%	0%	0%
40.59	Post-Acute Care	7%	93%	0%	0%	0%	0%	0%	0%
40.6	Pulmonary	0%	100%	0%	0%	0%	0%	0%	0%
99.94	(blank)	34%	45%	20%	0%	0%	0%	1%	0%
	TOTAL	21%	62%	11%	1%	0%	5%	1%	0%
	TOTAL OOS	**6,239**	**18,485**	**3,297**	**251**	**8**	**1,478**	**240**	**4**