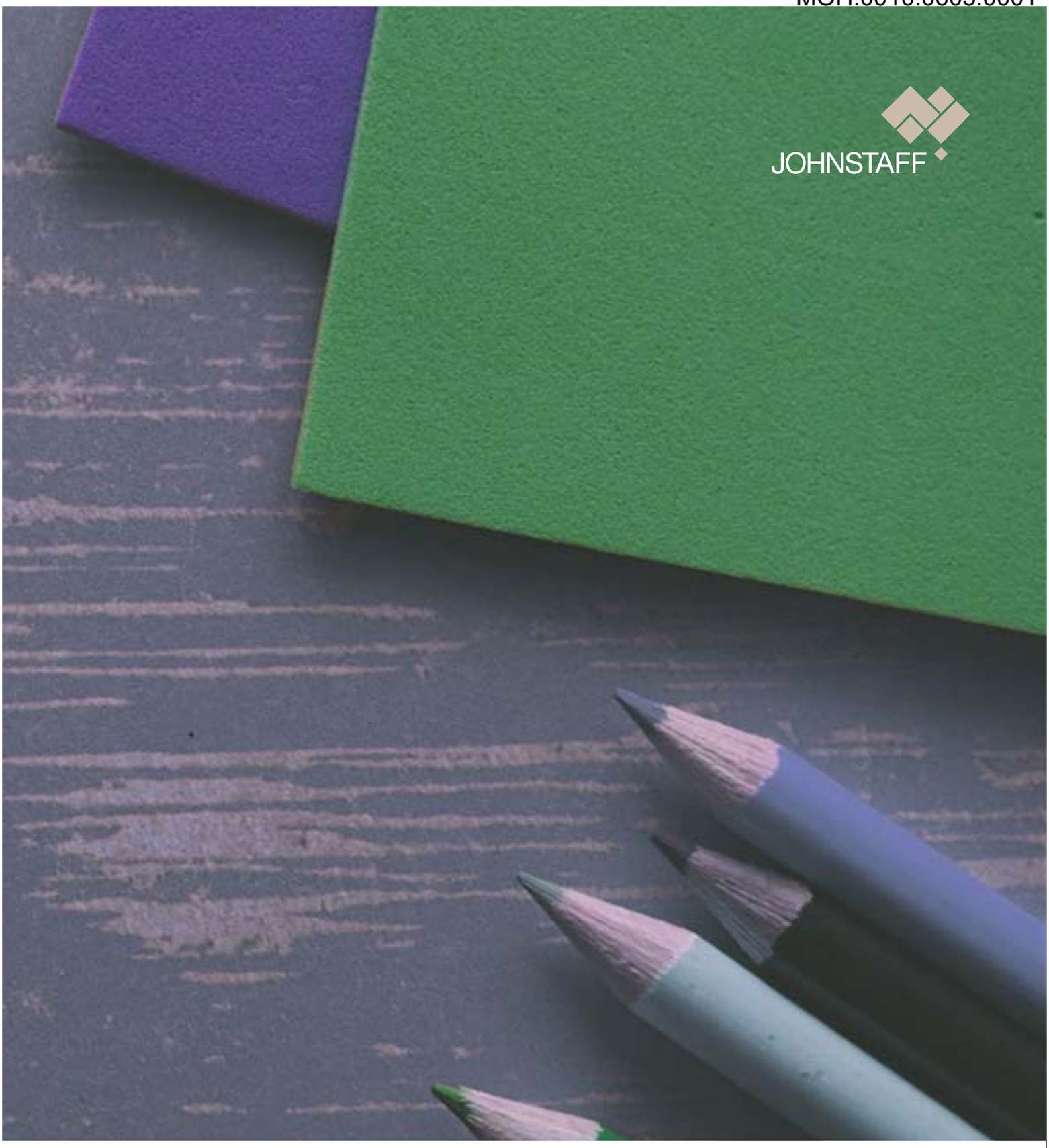

JOHNSTAFF

Service Planning: Wauchope District Memorial Hospital

Mid North Coast Local Health District

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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 Wauchope.

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 Wauchope 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

The Wauchope health services catchment population is older, with a median age of 48 years (compared to 38 years for NSW), and in June 2016 there were 3,175 Aboriginal and Torres Strait Islander peoples living in the region in 2016, accounting for 4.0 per cent of the population. Acknowledging this representation, stakeholders considered it essential 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.

Additional to being older, Port Macquarie - Hastings Local Government Area (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.

In recent years, the Wauchope community and surrounds has experienced several extreme weather events, and the COVID19 Pandemic, all of which have consequences for the health and wellbeing of the community. This, along with concerns raised regarding a lack of local access to and waiting times for mental health services, led stakeholders to emphasise a need to focus on mental health across all age groups.

Lastly, the Wauchope community has a strong history of involvement in, and shaping of, local health services. The key example of this is the award-winning Urgent Care Centre, which was established in partnership with the local community and key stakeholder groups in 2014. Stakeholders discussed the success of this project, and a keenness to extend this support to other collaborative ventures including the development of a local Youth Hub, which was raised as part of planning undertaken by the Port Macquarie-Hastings Council. Opportunities to collocate health and social services at locations other than the Wauchope Hospital were viewed positively. One reason for this, as discussed by service providers, would be to overcome limitations to local service provision related to the condition and suitability of infrastructure on the Wauchope Health Campus.

Stakeholder consultation with Mrs. Win Secombe, Community representative and President, Wauchope Hospital, United Hospital Auxiliaries

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, including for early intervention and rehabilitation
Patients have difficulty navigating systems	Access to specialist services
	Health promotion and support for parenting
	Services for Aboriginal community members
System integration is difficult	Non-emergency transport services
	Oral health services
	Support for carers

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 Wauchope 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 Wauchope District Memorial Hospital and Port Macquarie Hospital.

MNCLHD Strategy	Action
Establish, or participate in, a forum for service provider networking	1. Forging better relationships with other local providers, including aged care and NDIS providers, should be a priority for the service. A representative from Wauchope 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. 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 inreach 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

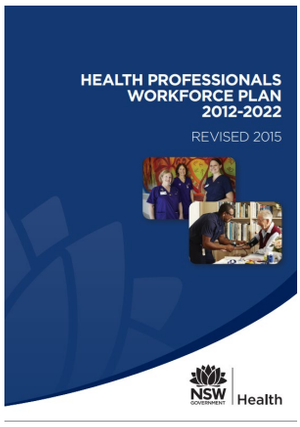
	activity is to increase understanding and connectivity between providers with a view to supporting patient access to the right care at the right time. 8. Once all local providers are engaged, canvass the possibility to partner with private providers for the provision of a local bereavement service.
Support parents, families and carers	9. Examine the local implementation of the First 2000 Days Framework (NSW strategic policy – PD2019_008) within Wauchope to guide the establishment of partnerships for the provision of parent and family services, which will involve a mapping exercise to identify who is operating locally, what they are providing (and to whom) and how their services are accessed. 10. Opportunities to partner for the provision of carer support services, where those services are not provided locally, should be canvassed.
Support community involvement in health and health service promotion	11. 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. This will include understanding those organisations already undertaking health promotion within the area (for example, through established newsletters, organised activities such as those organised by Omnicare for Dementia Awareness Week, and social media).
Access available infrastructure, looking for opportunities to collocate services	12. 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. 13. A Youth Hub, which has been identified as a community priority by the Port Macquarie-Hastings Council, was well supported by stakeholders as a potential location for collocated services, including health services. MNCLHD representatives should seek involvement in further Council planning to pursue this initiative.
Provide greater support for discharge planning and community service provider liaison	14. Increase resources for discharge planning from WDMH 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	15. Support the early identification of patient transport needs through discharge planning. 16. Examine opportunities to link point to point providers with nominated / scheduled public transport routes including the rail network. This will require strong engagement with community for-profit transport providers.
Enable better integration between MNCLHD services and improve local service access	17. Enhance the network patient flow model across MNCLHD, working as a hub with transport and smaller sites. 18. 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 as a potential way of avoiding unnecessary patient transfers to PMBH for these services. 19. Review technical and infrastructure enablers and local support requirements to ensure appropriate implementation of virtual models of care. 20. As local service access is in some cases limited, or does not support best practice care provision due to the condition and suitability of infrastructure, as capital funding is available, pursue the redevelopment of Wauchope Health Campus.
Focus on Aboriginal Health	21. Create a culturally safe space within Wauchope Hospital (close to the Urgent Care Centre as possible) to support patient and family discussions with Aboriginal patients. 22. Pursue opportunistic health checks and relevant brief interventions for Aboriginal family and community members attending the Urgent Care Centre. 23. 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 Wauchope	24. Advocate on behalf of Health for more affordable housing within Wauchope, including to the Port Macquarie-Hastings 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 Wauchope District Memorial 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 Hastings-Macleay 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.

Wauchope (through the Wauchope Chamber of Commerce) was successful in receiving two grants from the NSW Bushfire Community Resilience and Economic Recovery Fund:

- $10,000 for a Creative Wauchope 'Social-Distancing Festival', for art and craft tutors to deliver online workshops, and outdoor art installations in Bain Park
- $20,000 for an "Our way to recover" video and print content development and education campaign.

In addition, several local projects have been funded through the Commonwealth Bushfire Disaster Recovery Fund:

- $300,000 to the Wauchope Showground / Show Society, including $90k new amenity Block, and $210k contribution towards new stables
- $45,000 to the Bunyah Local Aboriginal Land Council, to develop a 10 person Aboriginal Cultural burning team, including a training program, PPE, chainsaws, mowers look after local Aboriginal Land Council properties.

3. Environmental Scan / Future Directions / Policy Framework

3.1 Environmental Scan

3.1.1 Port Macquarie-Hastings Council Planning

In May 2020, the Port Macquarie-Hastings Council released a Community Plan for Wauchope and Surrounds, which is a community-led blueprint that identifies key priorities and actions to achieve the community's vision – the responsibility for which will be shared between community and Council.

Council were able to contribute Wauchope community feedback on health matters, advising that following recent consultation the community expressed a desire to:

- Attract youth mental health services (there is a high suicide rate and no dedicated or outreach services in Wauchope, for example, headspace)
- Create a youth council and youth volunteer organisation, and secure a location for a youth hub to increase activities and support for young people
- Advocate for permanent, community-access facilities for community groups to meet and connect including disadvantaged groups
- Advocate for upgraded hospital facilities and services in Wauchope that complement existing services.
- Improve lighting close to sporting fields to encourage safe walking or cycling to and from sport after school
- Install outdoor fitness equipment
- Improve connectivity for pedestrians and cyclists, for example, from Wauchope to Beechwood / Wauchope to Port Macquarie
- Implement the Bain Park Master Plan (community and cultural hub / meeting space) - this Masterplan is currently being finalised by Council.

Port Macquarie-Hastings Council, in partnership with My Community Directory, provides a local community directory and diary. The online directory of community groups, services and facilities, provides up-to-date information for community organisations who provide services in the region as well as showing upcoming events in the area.

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.

> *"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."*

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

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, 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.

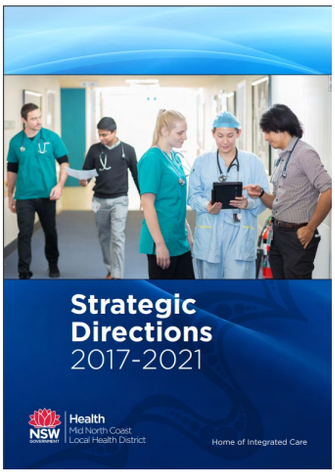
The agreed vision for NCC is to transition over time from our current disjointed approach to service commissioning and delivery to a dedicated regional commissioning model, thus recognising that even by delivering 'best practice' programming in our relative sectors we are often still failing to provide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

3.2 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
- Port Macquarie Clinical Services Plan 2010
- 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 Wauchope 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

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

- residents of the Port Macquarie – Hastings LGA form the primary catchment for Wauchope Health Campus
- Wauchope Health Campus 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 Wauchope Health Campus and Port Macquarie Hospital
- planners will be open to innovation to address identified service gaps, seeking to identify the best model to fill a particular need
- 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

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

- 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 Wauchope District Memorial 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.

4.3.3 Demand Analysis

While service activity is analysed for Wauchope Hospital, one limitation of the planning exercise relates to the ability to see the total demand for services by the residents of Wauchope. This is due to the fact that this type of analysis is undertaken at Local Government Area (LGA) level, and the residents of Wauchope belong to the Port Macquarie-Hastings LGA (which is the same LGA as residents of Port Macquarie).

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 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.

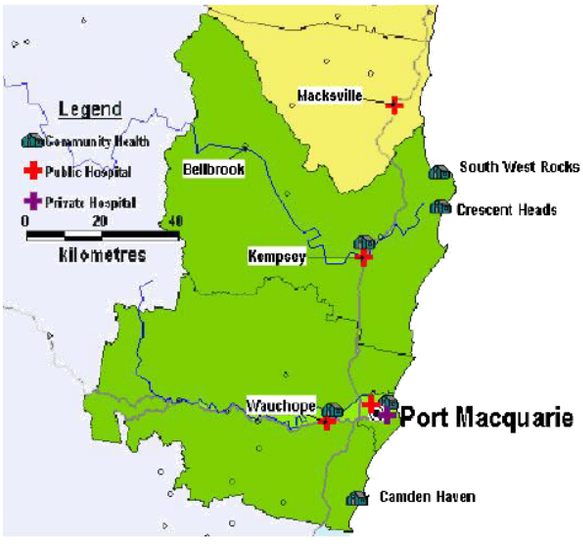
6. Wauchope District Memorial Hospital

The Wauchope Health Campus consists of Wauchope District Memorial Hospital (WDMH) and Wauchope Community Health Centre. WDMH provides 24-hour, level 2 / 3 services (see Appendix A – Role Delineation), and Is located in the Port Macquarie - Hastings LGA.

Medical services are provided by General Practitioners and specialist Surgeons and Anaesthetists contracted to the MNCLHD. WDMH currently has 18 inpatient beds in the main hospital consisting of eight Rehabilitation and 10 General Medical beds. In addition, Wauchope provides specialist Palliative Care services in a purpose built 8-bed Palliative Care Unit. There is one operating theatre for day-only surgery, including endoscopy, orthopaedic, gynaecology, vascular and urology.

The Community can access “walk-in” medical attention from the purpose-built Urgent Care Centre, which is opened from 8am to 6pm, 7 days per week. An Emergency Department is located 15 minutes away by car at Port Macquarie Base Hospital.

6.1 Clinical Network



WDMH is located within the Hastings Macleay Clinical Network (HMCN) in the south of the MNCLHD. Port Macquarie Base Hospital is the major referral hospital for the HMCN.

The HMCN covers an area of 7,074 square kilometres and is the southern Network of MNCLHD. This Network consists of two LGAs - Kempsey and Port Macquarie-Hastings, and shares its northern border with the Coffs Clinical Network, and its western and southern borders with 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 Port Macquarie - Hastings LGA was 80,073 persons, accounting for 1.0 per cent of the NSW population. There were 3,175 Aboriginal and Torres Strait Islander peoples living in the region in 2016, accounting for 4.0 per cent of the population.

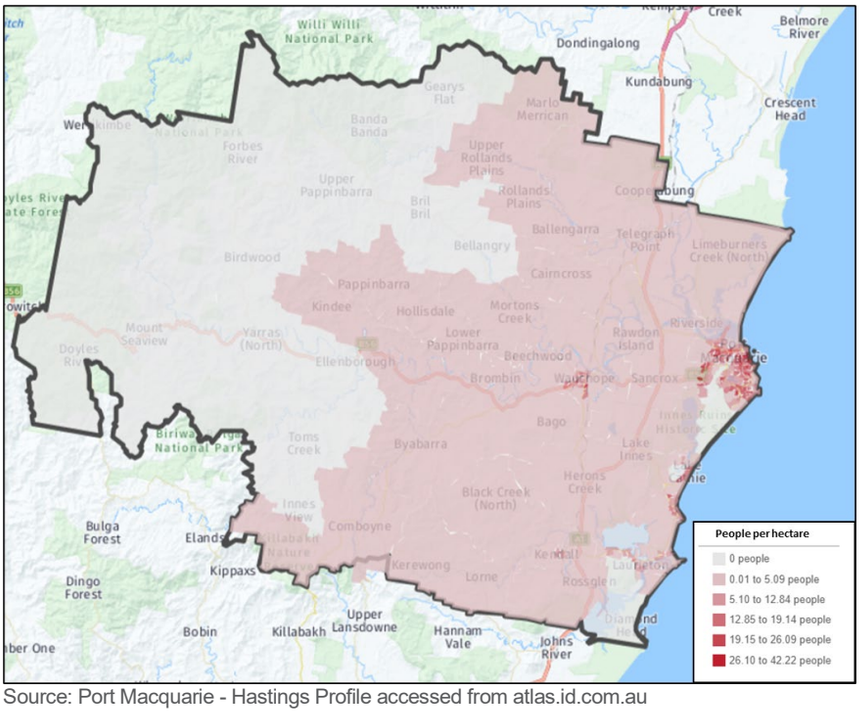
The catchment population has a different spread of age groups compared to the rest of NSW. The population of the region is older, with a median age of 48 years (compared to 38 years for NSW). Approximately 54 per cent of the LGA population was aged 45 years and over (compared to 40 per cent of the NSW population), and 27 per cent were aged 65 years and over (compared to 16 per cent of the NSW population).

The population is projected to increase to 96,445 people by 2036, an increase of 20 per cent on 2016, with an annual growth rate (AGR) of 0.9 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 and over will increase by 2036, while younger age groups will decrease. By 2031 those aged under 45 will account for 43 per cent of the population, while those aged over 65 will account for 33 per cent.

The figure below shows the distribution of the population (population density shown as number of persons per square kilometre) by SA1 for the LGA.

Figure 1 - Population Density, 2016, Port Macquarie - Hastings LGA



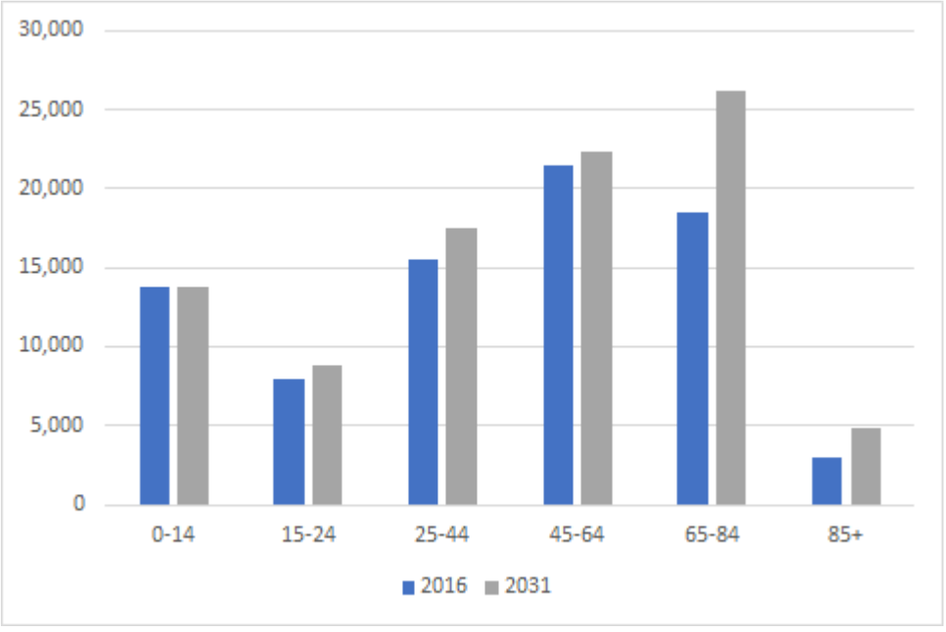
Source: Port Macquarie - Hastings Profile accessed from atlas.id.com.au

Table 1 - Population Projections by Age Group, 2021 to 2031 for the Primary Catchment

Age Group	2016	2021	2026	2031	% Change from 2016	% of Total 2016	% of Total 2031
0-14	13,778	13,929	13,692	13,728	1%	17%	15%
15-24	7,932	8,068	8,503	8,831	5%	10%	9%
25-44	15,461	16,293	17,094	17,552	13%	19%	19%
45-64	21,443	22,271	21,901	22,349	8%	27%	24%
65-84	18,472	21,002	23,878	26,140	49%	23%	28%
85+	2,987	3,307	3,791	4,798	103%	4%	5%
Total	**80,073**	**84,870**	**88,859**	**93,398**	**20%**	**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



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

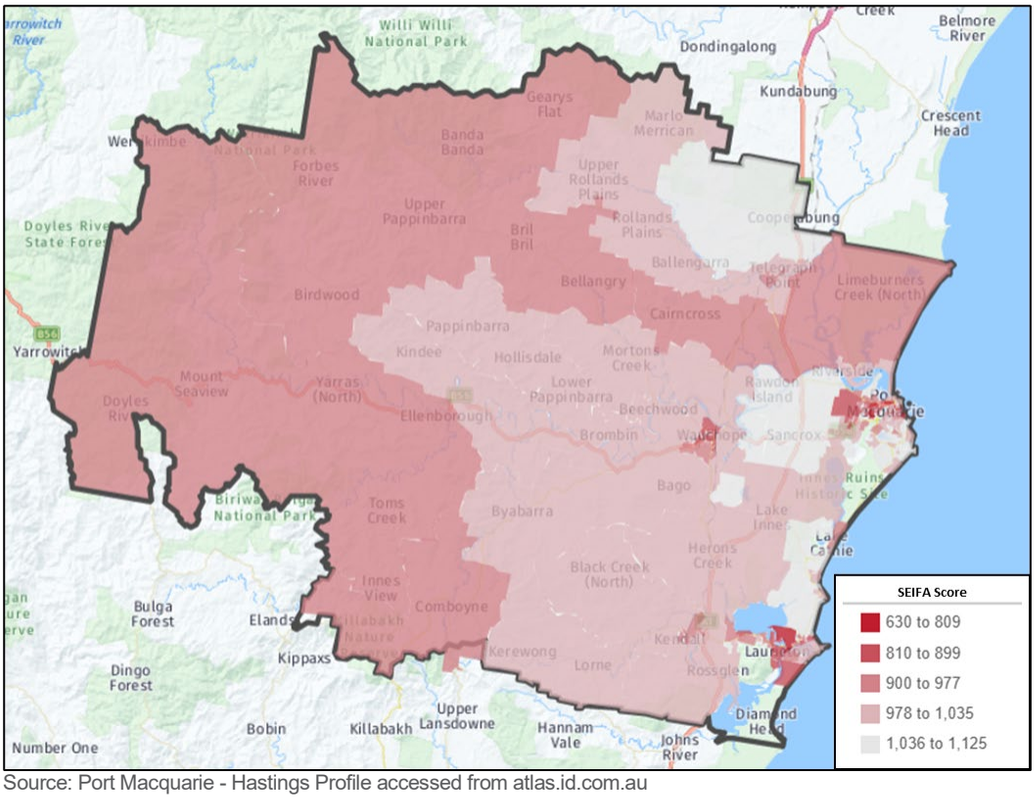
6.2.2 Socio-economic status

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, Port Macquarie - Hastings



Source: Port Macquarie - Hastings 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
Port Macquarie - Hastings	$1,042	6.8%	10.7%	21.0%	18.6%
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

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)
Port Macquarie-Hastings	71.4	9.9	6.6	9.8	13.1%	28.0
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, Port Macquarie - Hastings 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 Port Macquarie - Hastings 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 and Australia) shown in red.

Table 4 - Highlighted Health and Wellness Indicators and Risk Factors for Port Macquarie - Hastings LGA^

Indicator (%)	LGA	NSW	AUS
Obese adults (aged 18+)	36.0	30.9	31.3
Obese children (aged 2-17)	10.9	7.4	8.2

Current smokers	16.6	14.4	15.1
Alcohol consumption: more than 2 drinks per day	20.1	15.5	16.1
People with mental and behavioural problems	19.8	18.8	20.1
People with high/very high levels of psychological distress	12.9	12.4	12.9
Bowel cancer screening participation (% of invited people)	43.6	38.3	41.3
Breast screen participation in last 2 years (% of women 50-69)	61.5	52.8	n.d.
Adults with Asthma	13.3	10.6	11.2
Adults with Type 2 Diabetes	4.4	5.2	4.9
Adults with Heart / Vascular Disease	4.6	4.9	4.8
Adults with COPD	2.5	2.2	2.5
Adults with Arthritis	16.9	15.5	15.0
Self-reported dental health status as fair/poor	14.0	14.1	14.7
People who experienced a barrier to accessing healthcare in the last 12 months, with main reason being cost	3.3	2.5	2.0
Low birth weight babies (%)	5.0	5.2	6.1
Mothers smoking during pregnancy (%)	14.6	9.8	10.8
Children fully immunised at 5 years of age (%)	94.7	94.6	94.7
Deaths of persons aged 15 to 24 years (ASR / 100,000)	37.8	33.3	35.8
People with a profound or severe disability (%)	7.7	5.6	5.4
Median age at death (years)	83.0	82.0	81.0
Deaths from all avoidable causes (ASR / 100,000)	115.9	116.9	118.8
Cancer	31.3	27.3	28.4
Diabetes	6.0	6.3	6.4
Circulatory diseases	30.0	35.8	35.3
Respiratory diseases	9.9	10.6	10.2
External causes (Falls, burns, self-inflicted)	11.6	12.3	14.3
External causes (Transport, drownings)	16.2	15.1	15.6
Public hospital admissions (excl renal dialysis) (ASR / 100,000)	37,374	38,775	n.d.
Admissions for infectious and parasitic diseases	535.4	608.5	645.8
Admissions for cancer	1,252.6	1,095.8	1,280.6
Admissions for diabetes	115.4	139.1	168.9

Admissions for mental health related conditions	901.4	902.5	965.8
Admissions for nervous system diseases	772.1	607.7	786.3
Admissions for ischaemic heart disease	458.9	391.7	396.9
Admissions for stroke	195.9	210.9	213.8
Admissions for respiratory system diseases	1,270.5	1,514.1	1,587.7
Admissions for musculoskeletal system diseases	1,250.1	958.3	1,000.7
Admissions for genitourinary system diseases	1,397.8	1,067.7	1,178.1
Admissions for injury and other external causes	2,278.4	2,243.6	2,456.0
Potentially preventable public admissions (all conditions) (ASR/100,000)	2,209.1	2,223.7	2,388.6
Potentially preventable public admissions (chronic conditions) (ASR/100,000)	1,169.5	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.

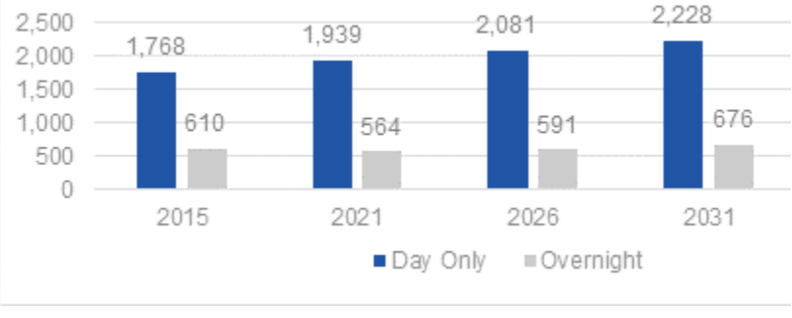
^Values are Aged Standardised Rate (ASR) per 100 unless otherwise noted

6.3 Current and Projected Service Activity

6.3.1 Inpatient Activity

The following figure and table provide a summary of overnight and same day separations at WDMH, as well as the top 5 SRGs (of greatest volume). The largest volume of services is for day surgical procedures including Diagnostic GI Endoscopy, Urology, Gynaecology and Gastroenterology, which account for 63 per cent of total activity. In 2015, 74 per cent of total activity were overnight episodes, and this pattern is expected to continue with 77 per cent of total episodes expected to be overnight in 2031.

Figure 4 - Total Overnight and Same Day Episodes, WDMH, 2015 - 2031



Source: NSW HealthApp

Table 5 - Total Episodes, Top 5 SRGs, WDMH, 2016

Top 5 SRGs (2016)	Episodes	%
Diagnostic GI Endoscopy	397	19.9%
Urology	377	18.9%
Gynaecology	260	13.0%

Orthopaedics	236	11.8%
Gastroenterology	223	11.2%
All other SRGs	506	25.3%
Total	**1,999**	**100%**

Source: NSW HealthApp

Overnight Services

The following table provides details of overnight medical and surgical service activity. Overnight activity at Wauchope is primarily for medical services. While total episodes will continue to grow, beddays are projected to decrease between 2016 and 2021 from 3,148 beddays to 1,471 beddays, and then progressively grow to 1,681 beddays by 2031.

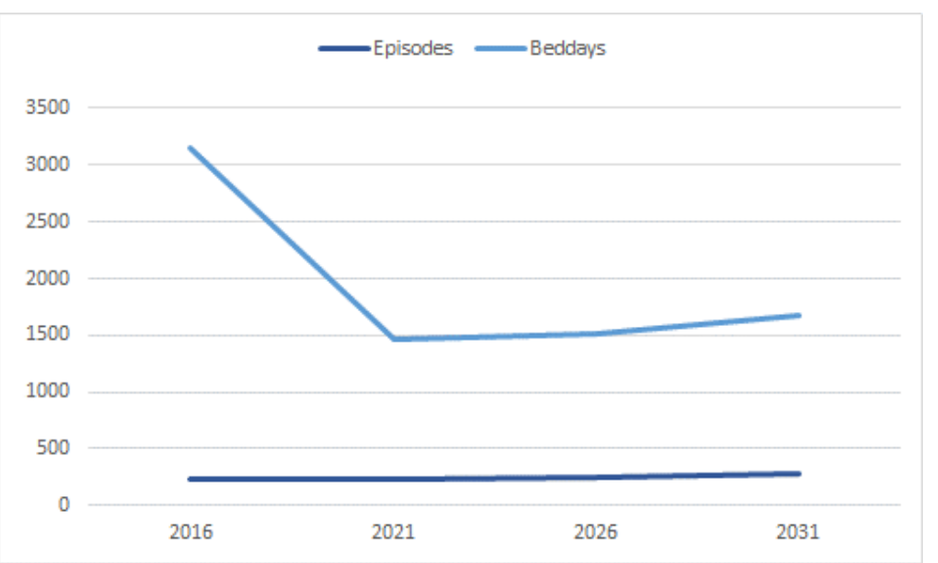
Of note, further enquiry is recommended with regard to the projected significant drop in medical beddays between 2016 and 2021, as seen in the table below. Initial discussions suggest that this may relate to care type changes, however at the time of report finalisation this has not been resolved.

Table 6 - Total Overnight Episodes and Beddays by Service Type, WDMH, 2016 - 2031

	Episodes				Beddays			
Service Type	2016	2021	2026	2031	2016	2021	2026	2031
Medical	224	231	244	274	3,096	1,445	1,497	1,665
Surgical	3	7	3	5	52	26	10	16
Total	**227**	**238**	**247**	**279**	**3,148**	**1,471**	**1,507**	**1,681**

Source: NSW HealthApp

Figure 5 - Total Overnight Episodes and Beddays, WDMH, 2016 - 2036



Source: NSW HealthApp

Same Day Services

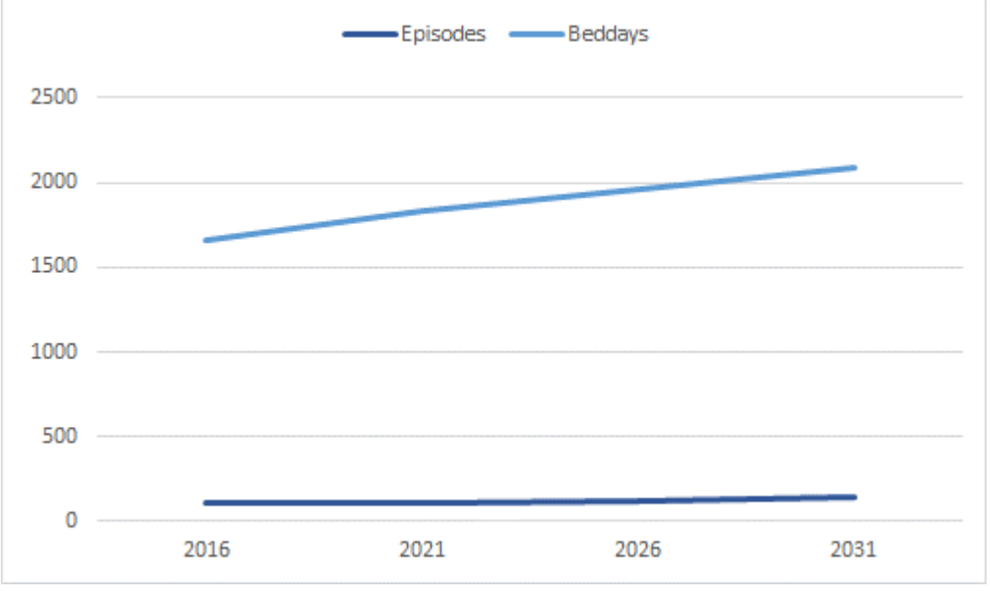
The following table provides details of same day medical and surgical service activity. There is a high volume of same day surgical activity at WDMH. Same day activity is projected to grow from 1,766 episodes in 2016 to 2,226 episodes by 2031, representing an increase of 26 per cent.

Table 7 - Total Same Day Episodes and Beddays by Service Type, WDMH, 2016 – 2031

	Episodes				Beddays			
Service Type	2016	2021	2026	2031	2016	2021	2026	2031
Medical	103	108	121	139	103	108	121	139
Surgical	1,663	1,829	1,958	2,087	1,663	1,829	1,958	2,087
Total	**1,766**	**1,937**	**2,079**	**2,226**	**1,766**	**1,937**	**2,079**	**2,226**

Source: NSW HealthApp

Figure 6 - Total Same Day Episodes by Service Type, WDMH, 2016 - 2031



Source: NSW HealthApp

Subacute Services

The following table provides details of subacute service activity at WDMH. Subacute activity is projected to grow from 379 episodes in 2016 (representing 4,936 beddays) to 391 episodes in 2031 (representing 4,605 beddays), representing a 16 per cent increase in episodes and a -7 per cent decrease in beddays.

Table 8 - Total Subacute Episodes and Beddays by Service Type, WDMH, 2016 – 2031

	Episodes				Beddays			
Service Type	2016	2021	2026	2031	2016	2021	2026	2031
Rehabilitation	126	135	139	157	2,429	2,357	2,373	2,652
Palliative Care	233	157	170	199	2,071	1,344	1,454	1,657
Maintenance	20	28	32	35	436	291	295	296
Total	**379**	**320**	**341**	**391**	**4,936**	**3,992**	**4,122**	**4,605**

Source: NSW HealthApp

Emergency Services

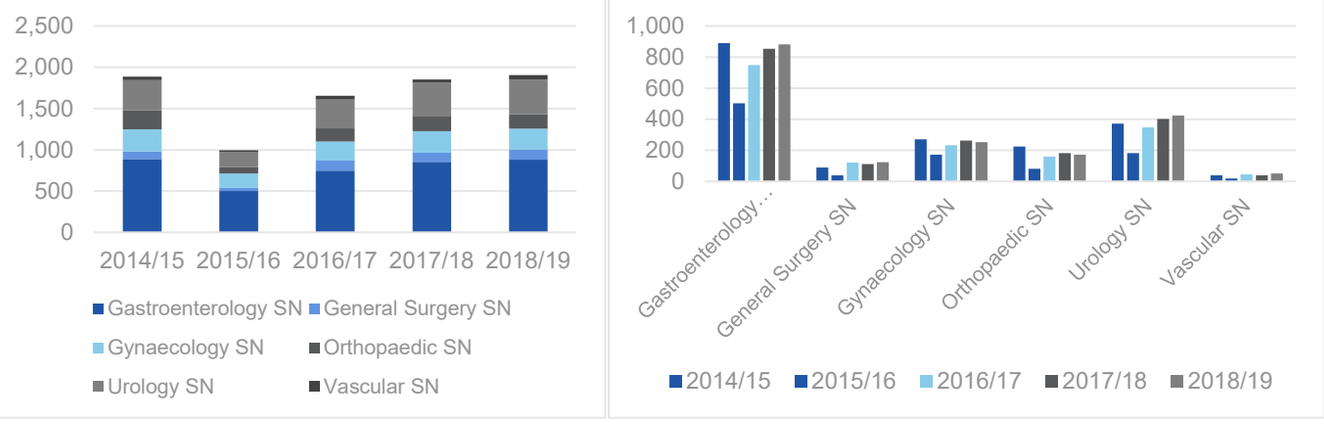
There is no emergency department at Wauchope District Memorial Hospital, however a “walk-in” Urgent Care Centre is available from 8am to 6pm, 7 days per week, and an Emergency Department is at Port Macquarie Base Hospital.

6.3.2 Surgical Activity and Flows

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

The following graphs and table provide details of surgical activity at WDMH (derived from Surginet data). WDMH primarily provides gastroenterology (46 per cent of total surgical activity) and other same day procedural services (Urology services constitute 22 per cent of total surgical activity and gynaecology services constitute 13 per cent of total surgical activity).

Figure 7 - Total Surgical Service Occasions by Specialty, WDMH, 2014/15 – 2018/19



Source: Surginet

Table 9 - Total Surgical Service Occasions by Specialty, WDMH, 2014/15 – 2018/19

Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	890	502	748	854	882
General Surgery SN	90	39	122	112	123
Gynaecology SN	270	173	232	262	253

Orthopaedic SN	225	81	160	183	172
Urology SN	371	182	347	403	424
Vascular SN	39	19	46	40	52
Total	**1,885**	**996**	**1,655**	**1,854**	**1,906**

Source: Surginet

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

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

In 2018/19, 49 per cent of total surgical service occasions were provided to patients aged 65+ years, 34 per cent to patients aged 45 – 64 years, and 17 per cent to patients aged 0 – 44 years.

Table 10 - Total Surgical Service Occasions by Specialty and Age, WDMH, 2014/15 – 2018/19

Specialty	Age	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	0-44	98	78	108	104	90
	45-64	362	193	292	291	331
	65+	430	231	348	459	461
General Surgery SN	0-44	26	18	33	30	26
	45-64	25	7	41	35	35
	65+	39	14	48	47	62
Gynaecology SN	0-44	158	100	141	161	144
	45-64	92	64	90	95	94
	65+	20	9	1	6	15
Orthopaedic SN	0-44	45	12	29	32	21
	45-64	91	37	75	80	76
	65+	89	32	56	71	75
Urology SN	0-44	34	24	32	33	29
	45-64	101	53	103	110	93
	65+	236	105	212	260	302
Vascular SN	0-44	13	4	11	10	16
	45-64	13	6	21	16	15
	65+	13	9	14	14	21
Total	**All ages**	**1,885**	**996**	**1,655**	**1,854**	**1,906**

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 WDMH. The average duration of a surgical procedure at WDMH remained relatively consistent between 2014/15 and 2018/19.

Table 11 - Total Annual Minutes for Surgical Procedures by Specialty, WDMH, 2014/15 – 2018/19

Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	19,517	11,379	17,399	20,533	21,181
General Surgery SN	3,210	1,536	4,323	4,258	4,744
Gynaecology SN	8,550	5,382	6,679	8,035	7,666
Orthopaedic SN	11,091	4,098	7,900	9,244	9,080
Urology SN	5,498	2,684	5,292	6,191	6,506
Vascular SN	3,096	1,438	3,653	3,397	4,421
Total Minutes	50,962	26,517	45,246	51,658	53,598
Average Duration	27.0	26.6	27.3	27.9	28.1

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 WDMH for surgical procedures.

Figure 8 - Total Surgical Service Occasions by Post Code of Residence, WDMH, 2014/15 – 2018/19

Patients at WDMH primarily reside in the immediate surrounding LGAs of Port Macquarie-Hastings and Kempsey (note that the figure displays this data by post code, not LGA).

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

- 83 per cent resided in the Port Macquarie-Hastings LGA
- 8 per cent resided in the Kempsey LGA.

Table 12 - Total Surgical Service Occasions by LGA of Residence and Specialty, WDMH, 2014/15 – 2018/19

LGA	Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Bellingen	Gastroenterology SN	0	0	0	1	0
	Gynaecology SN	0	0	0	0	1
	Urology SN	4	0	1	4	12
Bellingen Total		4	0	1	5	13
Coffs Harbour	Gastroenterology SN	0	0	1	0	0
	General Surgery SN	0	0		1	0
	Gynaecology SN	1	1	2	1	0
	Urology SN	3	2	2	3	16
Coffs Harbour Total		4	3	5	5	16
Kempsey	Gastroenterology SN	57	7	26	12	1
	General Surgery SN	0	1	0	1	0
	Gynaecology SN	62	35	52	63	59
	Orthopaedic SN	8	2	3	10	10
	Urology SN	85	39	86	96	86
	Vascular SN	4	1	4	4	6
Kempsey Total		216	85	171	186	162
Port Macquarie	Anaesthesia SN	2	0	0	0	0
	Gastroenterology SN	788	478	698	812	848
	General Surgery SN	85	37	118	109	122
	Gynaecology SN	195	126	168	184	185
	Orthopaedic SN	186	67	127	147	143
	Urology SN	231	121	223	257	256
	Vascular SN	28	14	32	27	27
Port Macquarie Total		1,515	843	1,366	1,536	1,581
Nambucca	Gastroenterology SN	4	1	1	1	0
	Gynaecology SN	3	1	1	1	3
	Orthopaedic SN	1	0	0	0	0
	Urology SN	11	5	9	20	17

	Vascular SN	2	0	0	1	1
Nambucca Total		21	7	11	23	21
Out of LHD	Gastroenterology SN	41	16	22	28	33
	General Surgery SN	3	1	4	1	1
	Gynaecology SN	9	10	9	13	5
	Orthopaedic SN	30	12	30	26	19
	Urology SN	37	15	26	23	37
	Vascular SN	5	4	10	8	18
Out of LHD Total		125	58	101	99	113
Total		**1,885**	**996**	**1,655**	**1,854**	**1,906**

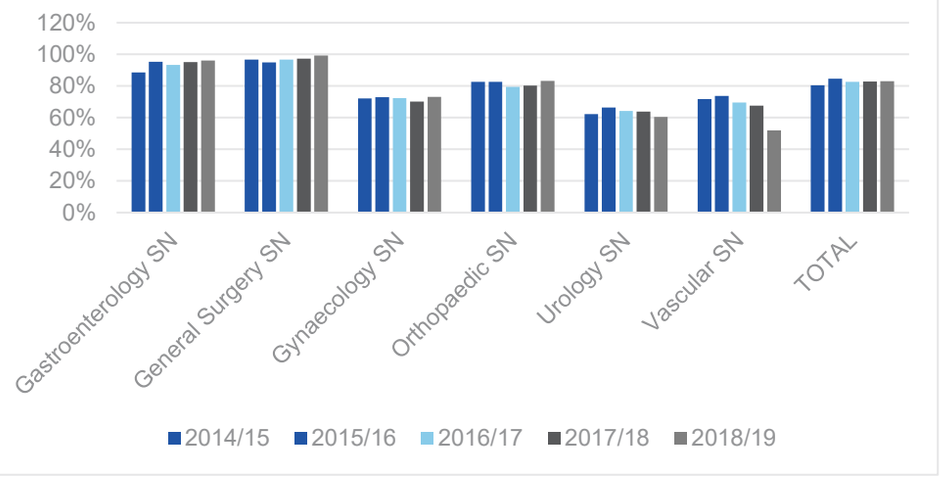
Source: Surginet

Percentage of Service Occasions from Port Macquarie-Hastings 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 WDMH that reside in the catchment LGA of Port Macquarie-Hastings.

In 2018/19, 99 per cent of Port Macquarie-Hastings LGA residents who received General Surgery services were provided those services from WDMH, 96 per cent of Port Macquarie-Hastings LGA residents who received Gastroenterology services were provided those services from WDMH, and 83 per cent of Port Macquarie-Hastings LGA residents who received Orthopaedic services were provided those services from WDMH.

Figure 9 - Total Surgical Service Occasions, Port Macquarie-Hastings LGA Residents, by Specialty, WDMH, 2014/15 – 2018/19



Source: Surginet

Table 13 - Total Surgical Service Occasions, Port Macquarie-Hastings LGA Residents, by Specialty, WDMH, 2014/15 – 2018/19

Specialty	2014/15	2015/16	2016/17	2017/18	2018/19
Gastroenterology SN	89%	95%	93%	95%	96%
General Surgery SN	97%	95%	97%	97%	99%
Gynaecology SN	72%	73%	72%	70%	73%
Orthopaedic SN	83%	83%	79%	80%	83%
Urology SN	62%	66%	64%	64%	60%
Vascular SN	72%	74%	70%	68%	52%
Total	**80%**	**85%**	**83%**	**83%**	**83%**

Source: Surginet

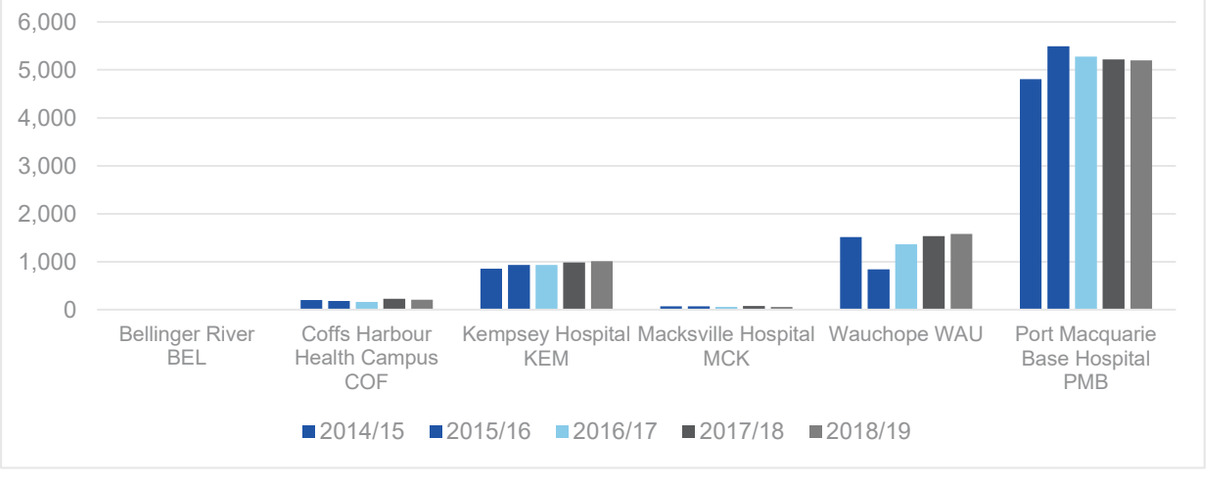
Service Occasions for Residents of Port Macquarie-Hastings LGA by MNCLHD Facility Attended, 2014/15 to 2018/19

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

In 2018/19:

- 64 per cent of Port Macquarie-Hastings LGA residents received their surgical service from Port Macquarie Base Hospital
- 20 per cent of Port Macquarie-Hastings LGA residents received their surgical service from Wauchope Hospital
- 13 per cent of Port Macquarie-Hastings LGA residents received their surgical service from Kempsey Hospital.

Figure 10 - Total Surgical Service Occasions, Port Macquarie-Hastings LGA Residents, by Specialty and Facility of Treatment, 2014/15 – 2018/19



Source: Surginet

Table 14 - Total Surgical Service Occasions, Port Macquarie-Hastings 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	1	4	6	12	18
Coffs Harbour Health Campus	202	184	164	229	210
Kempsey Hospital	856	930	934	987	1,014
Macksville Hospital	70	72	59	74	56
Wauchope	1,515	843	1,366	1,536	1,581
Port Macquarie Base Hospital	4,809	5,496	5,278	5,217	5,201
Total	7,453	7,529	7,807	8,055	8,080
Proportion attending Wauchope	**20%**	**11%**	**17%**	**19%**	**20%**

Source: Surginet

6.3.3 Outpatient and Non-Admitted Activity

The following table provides a summary of outpatient occasions of service at WDMH, with projections through to 2031. The largest volume of services is for Primary Health Care, which accounted for 36 per cent of total activity in 2018/19. Service activity is projected to decrease from 4,561 occasions of service in 2018/19 to 3,151 occasions in 2031/32, at an average AGR of -2.8 per cent.

Patient flows for residents of Port Macquarie-Hastings LGA attending outpatient appointments across MNCLHD are provided in Appendix C –. Of the 174,019 outpatient OOS for Port Macquarie-Hastings LGA residents in 2018/19, 150,555 were provided at Port Macquarie facilities (87 per cent self-sufficiency).

Aggregated Services	2016/17 Activity	2017/18 Activity	2018/19 Activity	2021/22 Activity	2026/27 Activity	2031/32 Activity
Primary Health Care	1,157	1,985	1,620	1,488	1,290	1,119
Wound Management	2,177	1,319	1,549	1,422	1,234	1,070
Allied Health / Other	1,494	1,651	1,392	1,278	1,109	962
Total	**4,828**	**4,955**	**4,561**	**4,188**	**3,633**	**3,151**

6.4 Current Workforce Profile

WDMH uses an average of 66.90 Full Time Equivalent (FTE) per fortnight, across a range of clinical and non-clinical professions / disciplines. The predominant workforce is nursing (64 per cent of total average workforce) followed by Corporate and Hospital Support Services staff (12 per cent of total average workforce).

Table 15 – Total Average FTE Used Per Fortnight by Award Code, WDMH, 2019/20

Award Codes	Total FTE	% Total
Nursing	42.75	64%
Corporate & Hospital Support	7.96	12%
Allied Health	7.36	11%
Hotel Services	6.35	9%
Medical (excluding VMOs)	1.71	3%
Scientific & Technical	0.77	1%
Total Average FTE used per fortnight	**66.90**	**100%**

Source: MNCLHD

6.5 Current and Projected Infrastructure

Projected infrastructure within the following 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 WDMH.

Table 16 - Projected Infrastructure by Service Type, WDMH, 2021 - 2031

Service Type	Current	2021	2026	2031
Adult ON Surgical	0	0.1	0.0	0.1
Adult ON Medical	10	4.7	4.8	5.4
Subacute*	16	12.2	12.5	14.0
Total ON				
Same Day	4	4.3	4.8	5.1
Total Beds		21.2	22.2	24.6
Operating Theatres	1	0.8	0.8	0.9
Outpatient Clinic Space	0	1.8	1.6	1.4

Notes:

- Wauchope Urgent Care Centre has four treatment spaces (seeing an average of 20 patients per day)
- Subacute includes 8 palliative care and 8 rehabilitation beds.

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 Wauchope 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 16th and 17th of September 2020, face to face consultations with community members and service providers were held at WDMH. 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 the following week. A full list of community and other service providers consulted is provided within 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:

> *"Having a network with representatives from all of the support organisations, where we can meet and make connections with each other, would be good. I'd like to know what's out there, we can tell people when we're delivering their meals. It would also help address the one-off situations that do occur".* Wauchope community stakeholder

- A local provider of aged care services discussed issues associated with receiving information from the hospital, which results in duplicated effort, increased costs and 'people having to tell their story over again'.
- 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"
- A local provider of community nursing services discussed a need for a contact for non-emergency discussions about clients – "just having that support would save a lot of presentations, we waste a lot of time working around this, they have to represent to ED and go through the whole chain again". Also "All referrals have come through Port, not through Wauchope – do they have a discharge planner?"

> *"We don't seem to get many referrals through from health or GPs in Wauchope. We've been here for a while, so I don't know why as we can get referrals from anybody, even someone's neighbour. Bundaleer is who we interact with most on the health and aged care side, the others are Port Macquarie based".* Wauchope community stakeholder

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.

> *"We have an access team, any new clients or even referrals that might not progress they do an assessment and we help them navigate My Aged Care. We've had to do this, it's really hard for them."* Wauchope community stakeholder

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 aged care provider and other non-Government service providers, 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.

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.

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.

Private service providers discussed the impact in a financial sense, which in an already austere environment, puts added pressure on the viability of these businesses.

> *"There used to be a walking group that went every Wednesday, that was pre-COVID. But that fell away. I miss the connection"*. Wauchope community stakeholder

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.

> *"Many of our clients are mental health patients, COVID has been really tough on them, but everyone has adapted well. It was tough at the start particularly with the schizophrenics, we are proud with how they've coped, but we have had a few deteriorate and we've had to send them to the ED"*. Wauchope community stakeholder

7.1.5 Understanding social factors at play

Community and affordable housing and homelessness

Several stakeholders made the point that community / affordable housing options are limited in Wauchope.

Consequently, homelessness was raised as an issue by Wauchope community stakeholders, however this was also raised specifically in relation to youth homelessness ("couch surfers, we have a lot of those").

"It's the surrounds that need to be looked at. We're getting more and more clients who are living well out of Wauchope – Beechwood, Byabarra – in the agricultural part of Wauchope. They're ageing out there and often they are ageing alone. We service them, but obviously it's more challenging." Wauchope community stakeholder

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, four hours of unfunded travel was discussed as 'unsustainable'.

Meeting the social and cultural needs of Aboriginal residents

Stakeholders discussed the Aboriginal population within Wauchope as having "grown significantly" and "the representation of youth who identify as Aboriginal who are attending primary school is actually greater than Kempsey".

With no Aboriginal Medical Service (AMS) in Wauchope, stakeholders acknowledged the difficulties of the Aboriginal residents accessing AMS Services, and as such there is a good utilisation of the Urgent Care Centre by Aboriginal residents. All stakeholders agreed that given this, making the space more culturally supportive, and delivering a culturally appropriate outdoor space for palliative care or bereavement at Wauchope Hospital "should be a key outcome of the planning exercise".

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, including General Practitioners (with "several practices advertising") discussed extended vacancies as driving limited services. Some concern was raised about lack of relief staff (Occupational Therapy and/or Physiotherapy staff were nominated) which then impacts discharging capability when staff are on leave in a timely way.

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

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 mental health services available to the community, delivered by several different agencies, but that nobody really 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".

Local General Practitioners also noted mental health as a 'huge concern' – "we're now referring to Sydney for telehealth consultations, it's hopeless getting access to Psychology, it's just not there".

> *"There are dozens of kids who are undiagnosed and unmedicated who would really benefit from diagnosis, but IF they can get in, THEN get to Port, it's $400 for a report to diagnose! Then it's the cost of medication, so the child comes off the medication and then they need to start from scratch. Also leads to self-medication, drug and alcohol issues and all that goes along with that."* Wauchope community stakeholder

MNCLHD staff noted that there are no mental health clinicians based at Wauchope, which is serviced from Port Macquarie, and therefore no local access to mental health services – "this is definitely a big gap". Stakeholders also raised that there was no local bereavement service, and considered that there should be options to consider how that might be delivered - "is there an opportunity to partner for this service?"

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

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 Port Macquarie.

The importance of ready access was highlighted with regard to early intervention models, which by definition require ready support within a nominated timeframe. Stakeholders involved in early childcare nominated waiting times for psychology, speech and occupational therapy as 'too long', and only available from Port Macquarie where "many families just won't be able to get there".

> *"It would be wonderful to have someone to talk to at Wauchope Hospital before a crisis, when the kid gets loaded into the ambulance and sent for assessment. Or Port Macquarie, I would call them if I had that contact too."* Wauchope community stakeholder

MNCLHD allied health staff, who are only providing visiting services to Wauchope, indicated that they would like to see increased capacity for child and family clinicians to provide services from 0-16 age group, however at present there is no appropriate space to provide services, nor appropriate technology to support access virtually.

Rehabilitative (allied health) services were also nominated by one stakeholder as 'missing, with not a lot of choice in the regional area, maybe one or two privates at best'. MNCLHD staff noted that they are limited in the types of patients that can be seen for inpatient rehabilitation, also due to infrastructure (for example, weight restrictions on equipment). Importantly, Wauchope Hospital lays a critical role in supporting patient flow across the network through the care and provision of rehabilitative services not just for aged persons but also for orthopaedic and post surgery patients. Given this, and the desire for Wauchope to take a stronger role in the provision of step down care within the networked arrangement for these services (with Kempsey and Port Macquarie), consideration should be given to addressing service limitations associated with infrastructure.

Both mental health and allied health staff were supportive of the idea of not being located at Wauchope hospital in the future – "a youth and family hub would work" and "it's useful to have multipurpose and collocated spaces from our [mental health] perspective".

> *"The Urgent Care Centre has a different profile to the inpatient area of the hospital, as it is predominantly children and youth that present. Access to early intervention services is a gap, one barrier is the physical space to be able to invite additional providers into the Urgent Care Centre, e.g. a hot office for psychologist, child and adolescent service providers, etc."* Wauchope staff member

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, particularly with regard to services for children. Extended waits for services from Port Macquarie were discussed.

> *"Assessments for autism – we know kids are on the spectrum but the waiting list is so long they're not diagnosed, meaning they can't access support through the NDIS. It's a missed window of opportunity and early intervention is critical to good outcomes for these kids. The impact lasts a lifetime."* Wauchope community stakeholder

Telehealth and virtual care were a direction keenly supported by staff although the current infrastructure both physical (consult space) and Information Technology (IT) are not really at a capable level to ensure delivery of a reliable service - "Inpatients are transferred to PMBH for a consult and may be away overnight or two nights – the bed has to be held – this just seems inefficient and very unsettling of the patient. It would be good if either the Registrar can come here or we can access the consult at the bedside using telehealth".

Community stakeholders also 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. With regard to outpatient services, stakeholders discussed:

- the sustainability of the Urgent Care Centre, which has been very successful, could be enhanced by basing more satellite services from Port Macquarie here, or making better use of telehealth / virtual care to provide access locally
- some residents with GP Management Plans[8] are hindered in optimising their health outcome because of the limited outpatient offerings at Wauchope.

Reflecting on the ageing population, specialist dementia services (day only) were noted as being provided by a local organisation (Omnicare), but that having a dementia friendly care facility is a local gap. Staff also noted that current facilities within Wauchope Hospital do not support best practice care for these patients.

7.2.4 Health promotion and support for parenting

Several stakeholders discussed independently organised health promotion activities. For example, Omnicare as a provider of specialist dementia services, was promoting dementia awareness week – "We are doing some things for this. I am not sure what Health is doing." Stakeholders discussed opportunities to harness existing platforms, and to coordinate activities across organisations, for broader dissemination of health promotion material. Platforms discussed included newsletters and social media platforms. MNCLHD providers of health promotion services noted that their work is focused on NSW Ministry of Health priorities, such as healthy eating and active living.

> *"What is available to help families raise their kids properly? Someone from Port used to come to do a course. Can you catch them when they have their blue book checked? It's really needed here."* Wauchope community stakeholder

Support and education for parenting was regularly raised by a broad cross-section of community stakeholders, including those identifying as Aboriginal. This included early years parenting, along with support for parents of children with mental health

[8] An GP Management Plan (GPMP) can be prepared by a GP for chronic disease management.

issues, drug and alcohol issues, and to “get them to stop eating so much sugar and drinking energy drinks all the time”. Notably, there are staff within the local education sector who are trained to do parenting programs “but due to COVID we can’t have groups. We can’t get parents onsite unless it’s for a disciplinary reason, so no parents groups onsite.”

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.

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. Planning for a Wauchope Youth Hub was supported by stakeholders working in Aboriginal Health.

Collaborations with Aboriginal Medical Services are being pursued along with the Primary Healthcare Network who are pursuing an opportunity to deliver transport services in collaboration with the Wauchope-based Bunyah Local Aboriginal Land Council, who has a good working relationship with MNCLHD.

> *“There is difficulty in Port being the place where it all happens. Allowing for the consumer voice and having a platform for this is needed, along with a multi-organisational approach to solutions – health can’t be responsible for everything.”* Aboriginal Health representative

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’.

Also discussed by stakeholders was good use of the Urgent Care Centre by patients, including youth, identifying as Aboriginal. With no Aboriginal Medical Service in Wauchope, “people are using it as a drop-in GP clinic”. With this in mind, a question was asked whether local medical staff could undertake opportunistic screening of family members. The Urgent Care Centre was also noted as lacking a culturally sensitive space, along with a lack of culturally appropriate outdoor space for palliative care or bereavement.

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, along with patient transport services which are brokered by MNCLHD Health Transport Unit. Stakeholders indicated that some patients resist moving from Port Macquarie Base Hospital to Wauchope for palliative care services “because of the transport barriers”.

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. Other stakeholders discussed local taxis as being expensive and public transport as being not well utilised (“there are no wheelchair accessible busses in Wauchope but there is one that comes from Port that is wheelchair accessible”).

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).

Of note, Port Macquarie-Hastings council representatives discussed an upgrade to Wauchope Station, that is being delivered as part of the Transport Access Program, which is a NSW Government initiative to provide a better experience for public transport customers by delivering accessible, modern, secure and integrated transport infrastructure across the state. The project, which is expected to be completed by early 2021, will provide a station precinct that is accessible to people with a disability, limited mobility, parents/carers with prams and customers with luggage.

7.2.7 Oral health

Oral health services were nominated by community members as a service gap in Wauchope, with staff noting that Wauchope does have an outlying clinic that only offers services for children, along with a small fleet of dental vans that deliver services (assessment and treatment) to children in the community (onsite at schools).

Adult services are only offered from hub sites (Port Macquarie), however private dental providers do operate locally in Wauchope including through an oral health fee for service scheme, where MNCLHD provide vouchers in a priority system for individuals to seek treatment from private dentists (this is budget driven and there are wait times and clinical prioritisation attached). Private practitioners in Wauchope are engaged in this scheme.

'Great challenges' were noted by MNCLHD staff in attracting dentists to the area.

7.2.8 Gaps in support for carers and the 'young aged'

Several stakeholders also promoted the importance of carer health, and identified that while there are local day programs available (for example, Omnicare has a 'be connected' program for carers), and that Bundaleer (a local residential aged care provider) offers respite care for eligible seniors, accessible for up to nine weeks in a calendar year, gaps exist for those carers who are not eligible for support through Bundaleer, and who require overnight respite.

Stakeholders also expressed concern for the 'young aged'. That is, individuals who are not aged (they might be under 60 years old) but still require assistance. These individuals may rely on the NDIS to fund their support needs, however they may not qualify for this either, and their age precludes them from aged-associated funding support.

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 Wauchope community and involve partners in solutions.

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

1. Forging better relationships with other local providers, including aged care and NDIS providers, should be a priority for the service. A representative from Wauchope 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.
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 inreach 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, 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.
8. Once all local providers are engaged, canvass the possibility to partner with private providers for the provision of a local bereavement service.

Supporting parents, families and carers

9. Examine the local implementation of the First 2000 Days Framework (NSW strategic policy – PD2019_008) within Wauchope to guide the establishment of partnerships for the provision of parent and family services, which will involve a mapping exercise to identify who is operating locally, what they are providing (and to whom) and how their services are accessed.
10. Opportunities to partner for the provision of carer support services, where those services are not provided locally, should be canvassed.

Supporting community involvement in health and health service promotion

11. 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. This will include understanding those organisations already undertaking health promotion within the area (for example, through established newsletters, organised activities such as those organised by Omnicare for Dementia Awareness Week, and social media).

Accessing available infrastructure, looking for opportunities to collocate services

12. 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.

13. A Youth Hub, which has been identified as a community priority by the Port Macquarie-Hastings Council, was well supported by stakeholders as a potential location for collocated services, including health services. MNCLHD representatives should seek involvement in further Council planning to pursue this initiative.

Greater support for discharge planning, and community service provider liaison services

14. Increase resources for discharge planning from WDMH 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

15. Support the early identification of patient transport needs through discharge planning.

16. Examine opportunities to link point to point providers with nominated / scheduled public transport routes including the rail network. This will require strong engagement with community for-profit transport providers.

Enabling better integration between MNCLHD services and improved local service access

17. Enhance the network patient flow model across MNCLHD, working as a hub with transport and smaller sites.

18. 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 as a potential way of avoiding unnecessary patient transfers to PMBH for these services.

19. Review technical and infrastructure enablers and local support requirements to ensure appropriate implementation of virtual models of care.

20. As local service access is in some cases limited, or does not support best practice care provision due to the condition and suitability of infrastructure, as capital funding is available, pursue the redevelopment of Wauchope Health Campus.

Focusing on Aboriginal Health

21. Create a culturally safe space within Wauchope Hospital (close to the Urgent Care Centre as possible) to support patient and family discussions with Aboriginal patients.

22. Pursue opportunistic health checks and relevant brief interventions for Aboriginal family and community members attending the Urgent Care Centre.

23. Ensure all health and health promotion activities consider the most effective and culturally appropriate manner for communicating with Aboriginal people.

Addressing homelessness in Wauchope

24. Advocate on behalf of Health for more affordable housing within Wauchope, including to the Port Macquarie-Hastings 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	Considerations / Dependencies	Timeline
Establishing, or participating in, a forum for service provider networking		
Forging better relationships with other local providers, including aged care and NDIS providers, should be a priority for the service. A representative from Wauchope 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.	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	This should occur through the service provider forum.	6 – 12 months

through the NDIS, or inreach 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, 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
Once all local providers are engaged, canvass the possibility to partner with private providers for the provision of a local bereavement service.	This should occur through the service provider forum. Further definition of the services required is needed.	12 – 24 months
Supporting parents, families and carers		

Examine the local implementation of the First 2000 Days Framework (NSW strategic policy – PD2019_008) within Wauchope to guide the establishment of partnerships for the provision of parent and family services, which will involve a mapping exercise to identify who is operating locally, what they are providing (and to whom) and how their services are accessed.	This should be for the consideration of MNCLHD Executive. Mapping should occur through the service provider forum.	12 – 24 months
Opportunities to partner for the provision of carer support services, where those services are not provided locally, should be canvassed.	This should occur through the service provider forum	12 – 24 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. This will include understanding those organisations already undertaking health promotion within the area (for example, through established newsletters, organised activities such as those organised by Omnicare for Dementia Awareness Week, and 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
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
A Youth Hub, which has been identified as a community priority by the Port Macquarie-Hastings Council, was well supported by stakeholders as a potential location for collocated services, including health services. MNCLHD representatives should seek involvement in further Council planning to pursue this initiative.	This should be for the consideration of MNCLHD Executive, however, support for this endeavour may also be provided through the service provider forum.	6 – 12 months
Greater support for discharge planning, and community service provider liaison services		

Increase resources and education for discharge planning from Wauchope Hospital to enable increased understanding of and connectivity with local service providers.	This should be for the consideration of MNCLHD Executive.	6 – 12 months
Establish a role for community service provider liaison, whose role is to network with and support networking between, health and social service providers operating in the community. Funding may be available for this role though the Primary Healthcare Network (as it is in other jurisdictions), with a view to establishing a permanently funded, ongoing position.	This should be for the consideration of MNCLHD Executive, in consultation with potential funders.	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
Examine opportunities to link point to point providers with nominated / scheduled public transport routes including the rail network. 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 as a potential way of avoiding unnecessary patient transfers to PMBH for these services.	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
As local service access is in some cases limited, or does not support best practice care provision due to the condition and suitability of infrastructure, as capital funding is available, pursue the redevelopment of Wauchope Health Campus.	This should be for the consideration of MNCLHD Executive, who may wish to engage with NSW Health Infrastructure, and progress further infrastructure-focused planning for the site.	As capital funding is available
Focusing on Aboriginal Health		
Create a culturally safe space within Wauchope Hospital (close to the Urgent Care Centre as possible) to support patient and family discussions with Aboriginal patients.	This should be for the consideration of MNCLHD Executive, and included within any infrastructure-focused planning for the site.	As capital funding is available
Pursue opportunistic health checks and relevant brief interventions for Aboriginal family and community members attending the Urgent Care Centre.	Consultation with MNCLHD Aboriginal Health staff and local Emergency Department staff is required to progress this action.	6 – 12 months
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 Wauchope, including to the Port Macquarie-Hastings 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 17 – Wauchope District Memorial Hospital Role Delineation

Services #	Service Type	Role Level: Old Guidelines (pre 2016)	Commentary for Change	Page Reference
Core Services				
1	Anaesthesia & Recovery	3	Can do ASA level 3 patients for anaesthesia	
2	Operating Suite	2		
3	Close Observation	NPS	No Planned Service	15
4	Intensive Care	NPS	No Planned Service	16
5	Nuclear Medicine	4	Not on-site, networked arrangements	18
6	Radiology & Interventional Radiology	3		
7	Pathology	3	Networked arrangement with Kempsey	21
8	Pharmacy	3		
Emergency Medicine				
A	Emergency Medicine	1	Urgent Care Centre	26
Medicine				
B1	Acute Stroke Services (Adult)	NPS	No Planned Service	30
B2	Cardiology & Interventional Cardiology	NPS	No Planned Service	33
B3	Chronic Pain Management	NPS	No Planned Service	35
B4	Clinical Genetics	NPS	No Planned Service	37
B5	Dermatology	NPS	No Planned Service	38
B6	Drug and Alcohol Services	1	close to Port Macquarie - Networked with Port Macquarie	40
B7	Endocrinology	2		
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	NPS	No Planned Service	51
B12	Immunology	NPS	No Planned Service	53
B13	Infectious Diseases	2		
B14	Neurology	2		
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	4		
B19	Renal Medicine	NPS	No Planned Service	68
B20	Respiratory and Sleep Medicine	2		
B21	Rheumatology	2		
B22	Sexual Assault Services	NPS	No Planned Service	74
B23	Sexual Health	1		
Surgery				
C1	Burns	NPS	No Planned Service	79
C2	Cardiothoracic Surgery	NPS	No Planned Service	81
C3	ENT Surgery	NPS	No Planned Service	83
C4	General Surgery	2		
C5	Gynaecology	2		

C6	Neurosurgery	NPS	No Planned Service	89
C7	Ophthalmology	NPS	No Planned Service	91
C8	Oral Health	3	1 chair dental service. Only providing dental services to children at the present time. May reintroduce adult services in the future.	93
C9	Orthopaedic Surgery	NPS	No Planned Service	95
C10	Plastic Surgery	NPS	No Planned Service	97
C11	Urology	2		
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	NPS	No Planned Service	114
D6	Surgery for Children	NPS	No Planned Service	116
D7	Youth Health	NPS	No Planned Service	118
Mental Health				
E1	Adult Mental Health	NPS	No Planned Service	121
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	2	Outreach Aboriginal Liaison officer – links with Port Macquarie	130
Community Health				
G	Community Health	2		

Appendix B – Steering Committee & Stakeholders Consulted

Table 18 – 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 19 – Stakeholders Consulted

Name	Position / Organisation
Win Secombe	Community representative and President, Wauchope Hospital United Hospital Auxiliary
Jo Hawkin	Wauchope Preschool Kindergarten
Raymond Gouck	CEO, Bundaleer Care Services Ltd
Liesa Davies	Group Manager Economic and Cultural Development, Port Macquarie-Hastings Council
Duncan Coulton	Acting Director Strategy and Growth, Port Macquarie-Hastings Council
Dr Phillip Ewart	General Practitioner, Hastings Medical Centre
Raelene Monkley	Community representative
Sonia Shields	Community representative
Sarah McGarrity	Coordinator, Day Centres, Omnicare
Sheree Burnham	Relieving Deputy Principal, Wauchope High School
Anna Wilson	Social Worker, Wauchope High School
Andrew Temple	Manager, Busways Wauchope
Alvena Ferguson	Meals on Wheels Coordinator, Omnicare
Melissa Freeman	Port Macquarie District Nursing Service
John Alford	Acting Health Relationship Manager, Peer Support Officer

	Regional Operations/Mid-North Coast Sector, NSW Ambulance
Rennay Miller	Community Housing Ltd NSW
Sharyn Robbins	Community Housing Ltd NSW
Leah Wright	Community Housing Ltd NSW
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	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
Cher James	Administration Support Officer, Wauchope Community Health Centre
Joe Bryant	Aboriginal Health Program Coordinator Mid North Coast Local Health District
Helen Byrnes	A/Executive Officer Director of Nursing, Wauchope District Memorial Hospital
Judith Beilby	Nurse Manager, Wauchope District Memorial Hospital
Catherine Williams	NUM Rehab Ward/Urgent Care Centre, Wauchope District Memorial Hospital
Dr Will Kennett	Staff Specialist Palliative Care, Wauchope District Memorial Hospital
Dr Roslyn Avery	VMO Rehabilitation Physician, Wauchope District Memorial Hospital
Carmel Ireland	District Manager Oral Health Mid North Coast Local Health District
Dr Alan Forrester	HMN Director Emergency
Mary Trotter	NUM Palliative Care Unit, Wauchope District Memorial Hospital
Deborah Jones	Finance Officer, Wauchope District Memorial Hospital
Anthony Best	Physiotherapy Manager, PMBH/Wauchope District Memorial Hospital
Ben Walkling	A/Occupational Therapy Manager, PMBH/Wauchope District Memorial Hospital

Appendix C – Outpatient Flows

Residents of Port Macquarie-Hastings LGA

Code	Tier 2 Name	Bellingen	Camden	Coffs Harbour	Drugs and	Hastings	Kempsey	Macksville	Port	South West	Wauchope	Wauchope
10.02	Interventional Imaging	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%
10.03	Minor Surgical	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.1	Renal Dialysis - Hospital	0%	0%	0%	0%	0%	0%	91%	9%	0%	0%	0%
10.11	Chemotherapy -	0%	0%	1%	0%	0%	0%	0%	99%	0%	0%	0%
10.12	Radiation Therapy -	0%	0%	3%	0%	0%	0%	0%	97%	0%	0%	0%
10.13	Minor Medical	0%	0%	5%	0%	0%	0%	0%	95%	0%	0%	0%
10.14	Pain Management	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%
10.18	Enteral Nutrition -	0%	0%	5%	0%	0%	0%	0%	95%	0%	0%	0%
10.2	Radiation Therapy -	0%	0%	2%	0%	0%	0%	0%	98%	0%	0%	0%
20.02	Anaesthetics	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.05	General Medicine	0%	0%	0%	0%	0%	0%	0%	38%	0%	0%	62%
20.06	General Practice and	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.07	General Surgery	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.08	Genetics	0%	0%	1%	0%	0%	0%	0%	99%	0%	0%	0%
20.09	Geriatric Medicine	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.11	Paediatric Medicine	0%	0%	0%	0%	0%	1%	0%	99%	0%	0%	0%
20.12	Paediatric Surgery	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.13	Palliative Care	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.15	Neurology	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.24	Vascular Surgery	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
20.25	Gastroenterology	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%
20.26	Hepatobiliary	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.28	Metabolic Bone	0%	0%	14%	0%	0%	0%	0%	86%	0%	0%	0%
20.29	Orthopaedics	0%	0%	2%	0%	0%	0%	0%	98%	0%	0%	0%
20.34	Endocrinology	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.38	Gynaecology	0%	0%	5%	0%	0%	0%	0%	95%	0%	0%	0%
20.42	Medical Oncology	0%	0%	4%	0%	0%	0%	0%	96%	0%	0%	0%

20.43	Radiation Oncology	0%	0%	3%	0%	0%	0%	0%	97%	0%	0%	0%
20.44	Infectious Diseases	0%	0%	76%	0%	0%	0%	0%	24%	0%	0%	0%
20.45	Psychiatry	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
20.47	Rehabilitation	0%	0%	38%	0%	0%	0%	0%	62%	0%	0%	0%
20.52	Addiction Medicine	0%	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%
30.01	General Imaging	0%	0%	9%	0%	0%	5%	3%	0%	0%	0%	83%
30.08	Clinical Measurement	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.02	Aged Care Assessment	0%	0%	48%	0%	0%	0%	0%	52%	0%	0%	0%
40.03	Aids and Appliances	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.05	Hydrotherapy	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.06	Occupational Therapy	0%	0%	0%	0%	0%	0%	1%	99%	0%	0%	0%
40.07	Pre-Admission and Pre-	0%	0%	2%	0%	0%	2%	0%	80%	0%	0%	15%
40.08	Primary Health Care	0%	7%	0%	0%	0%	1%	1%	83%	0%	6%	0%
40.09	Physiotherapy	0%	7%	0%	0%	0%	2%	2%	79%	0%	0%	10%
40.1	Sexual Health	0%	0%	8%	0%	0%	12%	0%	80%	0%	0%	0%
40.11	Social Work	0%	0%	1%	0%	0%	1%	0%	96%	0%	0%	1%
40.12	Rehabilitation	0%	0%	1%	0%	0%	0%	0%	99%	0%	0%	0%
40.13	Wound Management	0%	24%	0%	0%	0%	4%	1%	51%	0%	19%	0%
40.14	Neuropsychology	0%	0%	8%	0%	0%	0%	0%	92%	0%	0%	0%
40.17	Audiology	0%	0%	1%	0%	0%	0%	0%	99%	0%	0%	0%
40.18	Speech Pathology	0%	0%	0%	0%	0%	1%	5%	94%	0%	0%	0%
40.21	Cardiac Rehabilitation	0%	0%	0%	0%	0%	1%	0%	99%	0%	0%	0%
40.22	Stomal Therapy	0%	0%	0%	0%	0%	14%	0%	86%	0%	0%	0%
40.23	Nutrition/Dietetics	0%	0%	1%	0%	0%	47%	0%	52%	0%	0%	0%
40.25	Podiatry	0%	0%	1%	0%	0%	9%	0%	90%	0%	0%	0%
40.27	Family Planning	0%	0%	0%	0%	0%	1%	0%	99%	0%	0%	0%
40.28	Midwifery and	0%	0%	1%	0%	0%	1%	1%	96%	0%	0%	0%
40.29	Psychology	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.3	Alcohol and Other	0%	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%
40.32	Continence	0%	0%	0%	0%	0%	99%	1%	0%	0%	0%	0%
40.35	Palliative Care	0%	0%	16%	0%	0%	57%	27%	0%	0%	0%	0%
40.36	Geriatric Evaluation	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%

40.38	Infectious Diseases	0%	0%	10%	0%	0%	0%	0%	90%	0%	0%	0%
40.39	Neurology	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.4	Respiratory	0%	0%	0%	0%	0%	5%	1%	94%	0%	0%	0%
40.42	Circulatory	0%	0%	1%	0%	0%	0%	2%	97%	0%	0%	0%
40.43	Hepatobiliary	0%	0%	1%	0%	0%	0%	0%	99%	0%	0%	0%
40.44	Orthopaedics	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.46	Endocrinology	0%	0%	3%	0%	0%	1%	0%	96%	0%	0%	0%
40.47	Nephrology	0%	0%	2%	0%	0%	0%	0%	98%	0%	0%	0%
40.49	Gynaecology	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.51	Breast	0%	0%	2%	0%	0%	0%	0%	98%	0%	0%	0%
40.52	Oncology	0%	0%	4%	0%	0%	0%	0%	96%	0%	0%	0%
40.55	Paediatrics	0%	0%	1%	0%	0%	8%	0%	91%	0%	0%	0%
40.57	Cognition and Memory	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
40.58	Hospital Avoidance	0%	0%	3%	0%	0%	0%	0%	34%	0%	63%	0%
40.59	Post-Acute Care	0%	0%	2%	0%	0%	0%	0%	98%	0%	0%	0%
40.6	Pulmonary	0%	0%	2%	0%	0%	0%	0%	98%	0%	0%	0%
99.94	(blank)	0%	0%	2%	0%	0%	6%	0%	93%	0%	0%	0%
99.96	(blank)	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%
	TOTAL	**0%**	**2%**	**2%**	**3%**	**0%**	**1%**	**1%**	**87%**	**0%**	**2%**	**2%**
	TOTAL OOS	**6**	**4,048**	**3,689**	**5,343**	**98**	**2,276**	**1,132**	**150,555**	**1**	**3,129**	**3,742**