Northern NSW
Local Health District

NSW GOVERNMENT

# Health Care Services Plan

## Priority Focus Areas

March 2024

# Acknowledgement of Country

Northern NSW Local Health District acknowledges the Traditional Custodians of the lands and waters where we work and live. We pay our respects to Elders past and present, and extend this respect to all Aboriginal people.

Health Care Services Plan

## More information

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# Glossary

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| AMP | Asset Management Plan |
| AOD | Alcohol and other drugs |
| BDH | Ballina District Hospital |
| CDMH | Casino and District Memorial Hospital |
| CIP | Capital Investment Proposal |
| CSP | Clinical Services Plan |
| EOA | Early Options Analysis |
| EV | Electric vehicle |
| FY | Financial year |
| GBH | Grafton Base Hospital |
| GEM | Geriatric evaluation and management |
| HITH | Hospital in the Home |
| IACC | Integrated Ambulatory Care Centre |
| IPTAAS | Isolated Patients Travel and Accommodation Assistance Scheme |
| IPU | Inpatient unit |
| KPI | Key performance indicator |
| LBH | Lismore Base Hospital |
| LBVC | Leading Better Value Care |
| LGBTIQ+ | Lesbian, gay, bisexual, transgender, intersex, queer and other sexuality and gender diverse people |
| LHD | Local Health District |
| MDH | Maclean District Hospital |
| MHSSU | Mental health short stay unit |
| MME | Major medical equipment |
| MNC | Mid North Coast |
| MPS | Multi-Purpose Service |
| NGO | Non-government organisation |
| NNSW | Northern NSW |
| PRM | Patient Reported Measure |
| RACF | Residential aged care facility |
| SA2 | Statistical area level 2 |
| SAMP | Strategic Asset Management Plan |
| SES | State Emergency Service |
| SN | Specialty Network |
| SSU | Short stay unit |
| TVH | Tweed Valley Hospital |

# Contents

# 1 Introduction

## 1.1 About this Plan

LHDs have a responsibility to effectively plan services over the short- and long-term to enable service delivery that is responsive to the health needs of its defined population. This Plan – the Health Care Services Plan (HCSP) – is a comprehensive planning document that provides the service direction and priorities for NNSWLHD over a five-to-ten-year horizon, with specific focus on the issues which affect the health of the catchment population and the delivery of services. All LHDs and Specialty Networks (SNs) in NSW are required to develop a HCSP.

The Plan is centred around Priority Focus Areas, reflecting guidance and templates from the NSW Ministry of Health. Development of the Priority Focus Areas was informed through extensive consultation and engagement processes, as well as aligning with local and state-wide priorities and guiding frameworks, such as Future Health 2022-2032 and the NSW Regional Health Strategic Plan 2022-2032.

When progressing the actions articulated in this Plan, NNSWLHD will have a focus on strong partnership approaches and working closely with key stakeholders to ensure that health services are high-quality, high-value and sustainable into the future. The 'right care, right time, right place, right clinician' principle is a central component of this which will support a focus on the whole lifespan and care continuums, including the importance of prevention, early intervention and improving the health of the community.

## 1.2 Northern NSW LHD context

Northern NSW LHD (NNSWLHD) covers an area of 20,732km$^2$ located in north-eastern NSW extending from Tweed Heads in the north, to Tabulam and Urbenville in the west, and to Nymboida and Grafton in the south. NNSWLHD spans seven Local Government Areas (LGAs); Ballina, Byron, Clarence Valley, Kyogle, Lismore, Richmond Valley, and Tweed. The Traditional Custodians of the land covered by NNSWLHD are the Bundjalung, Yaegl, Gumbaynggirr and Githabul Nations.

NNSWLHD provides a diverse range of health services to over 311,000 residents through a mix of hospitals, multi-purpose services (MPSs), community health centres, HealthOne services and other facilities. The LHD operates within a broader health and social care system that deliver health and wellbeing services and programs along a continuum, ranging from acute inpatient care delivered in hospital settings, through to community- and population-based programs delivered through other government, non-government and community agencies.

Over 5,500 people work across NNSWLHD facilities to support the delivery of general and specialist healthcare to the local community as well as visitors to the region.

### 1.2.1 Northern NSW LHD population

To inform service planning, the current and future population profile of NNSWLHD is considered. This comes from a range of data and information sources, including Census data from the Australian Bureau of Statistics and population projection data from the NSW Department of Planning, Housing and Infrastructure. The NSW population projections are a set of common planning assumptions that NSW Government and external agencies use as a consistent evidence base to plan services and infrastructure. Supporting data and information from other entities, such as Local Councils, is also

used to understand the local context and projected change, such as through growth plans, development and school enrolments.

Census data shows that the NNSWLHD population has grown 7.2% between 2016-2021 to a total population of 311,508 people. Population growth across NNSWLHD has been higher in the coastal LGAs of Byron (14.5%), Ballina (10.8%), Clarence Valley LGA (6.8%) and Tweed (6.6%), while the more rural LGAs of Kyogle (4.7%), Richmond Valley (3.3%) and Lismore (2.8%) have grown more slowly.

The population is projected to continue to grow over the coming years, up 5.3% between 2021 and 2031. Like past years, growth will be highest in the coastal areas of the LHD. Along with overall population growth, the population is ageing and there is a shifting composition toward a higher proportion of older people residing in the LHD. In 2021, 25% of the LHDs population was aged 65 years or over (77,741 people) and by 2031, this is projected to increase to 30% (or over 95,600 people).[1]

The NNSWLHD population is diverse in its composition, and compared to NSW and Australian averages, has:

- a higher proportion of people identifying as Aboriginal or Torres Strait Islander.
- lower levels of educational attainment, lower median income, lower levels of people who are in full-time employment and high levels of unemployment.
- high levels of rental and housing stress.
- pockets of high socioeconomic disadvantage (Clarence Valley, Kyogle and Richmond Valley) and advantage (Ballina and Byron).[2]

There is also significant diversity across and within LGAs in terms of demography, such as high variation in levels of socioeconomic advantage and disadvantage across statistical area level 2 (SA2) in the Ballina LGA.

In terms of health status and outcomes, NNSWLHD, compared to NSW averages, has:

- higher rates of hospitalisation for a range of accident, illness and disease types including type 1 diabetes, fall-related injuries, intentional self-harm, acute respiratory infections and chronic kidney disease.[3]
- higher proportion of adults with mental and behavioural problems (all LGAs excluding Ballina), chronic obstructive pulmonary disease (all LGAs excluding Ballina), current smokers (all LGAs excluding Ballina), high alcoholic intake/more than two standard drinks per day on average.
- similar or higher cancer screening participation rates.
- higher age standardised rates of some cancer types, notably melanoma which is higher across all LGAs.[4]

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[1] NSW Department of Planning, 2022 NSW Population Projections: Population projections | Planning (nsw.gov.au)

[2] Australian Bureau of Statistics, Census 2021 Quickstats: 2021 Australia, Census All persons QuickStats | Australian Bureau of Statistics (abs.gov.au)

[3] HealthStats NSW, Hospitalisations by LHD: Hospitalisations - HealthStats NSW

[4] Public Health Information Development Unit, Social Health Atlas of Australia, NSW, Data by LGA, Published December 2022 and September 2023; Cancer NSW, 2014 to 2018 statistics

These measures of demographics and health status highlight the diversity in the population of the region and the subsequent impacts on overall health and healthcare needs. These measures are often interrelated and can have a compounding effect on the health and wellbeing of individuals and communities. Vulnerable populations and those in lower socioeconomic groups generally are at greater risk of poor health, have higher rates of illness, disability and death, and live shorter lives than those in higher socioeconomic groups.[5] These risks can also be heightened by location, with rural and remote communities having poorer health outcomes which can be multifactorial including poorer access to primary care and other health services as well as differences in lifestyle, levels of disadvantage and opportunity.[6] Recognising and addressing these factors is central in planning and delivering health services across the full continuum from health promotion and prevention through to acute clinical services.

Further detail on the NNSWLHD population and future projections is at Appendix A.

## 1.3 Governance

The development of this Plan was overseen by a Steering Committee, the Clinical Planning and Clinician Engagement Committee. The Committee provided guidance and advice, including to:

- make recommendations on the direction of and inclusions within the Plan to ensure it meets its objectives.
- ensure adequate and appropriate consultation is undertaken to inform development of the Plan.
- ensure alignment to strategic, clinical and operational priorities.
- recommend items or issues for escalation to the executive team, if required.
- maintain accountability to set timelines for delivery, whilst being cognisant that flexibility is needed in cases where other priorities arise.

Membership of the Committee is at Appendix B.

## 1.4 Consultation

The NNSWLHD workforce, service delivery partners, community representatives and other stakeholder groups were engaged in the development of this Plan. This included both structured and informal consultation and engagement approaches which supported the identification of key themes, challenges and future priorities for NNSWLHD and the services it delivers. These aspects were synthesised into the Priority Focus Areas outlined in this Plan.

A full consultation list is at Appendix C.

[5] Australian Institute of Health and Welfare, 'Health across socioeconomic groups', Web article, 7 July 2022: Health across socioeconomic groups - Australian Institute of Health and Welfare (aihw.gov.au)

[6] Australia Institute of Health and Welfare, 'Rural and remote health', Web article, 11 Sept 2023: Rural and remote health - Australian Institute of Health and Welfare (aihw.gov.au)

# 2

# Priority Focus Areas

## 2.1 Priority overview

Seven Priority Focus Areas have been identified as key service development areas for NNSWLHD over the coming years. These Priority Focus Areas are interrelated and mutually reinforcing, with actions that will support progress across multiple Priority Focus Areas. The details of each should be read as a collective set of actions that will shape service delivery in NNSWLHD.

While these seven Priority Focus Areas are explicitly outlined in this Plan, NNSWLHD will continue to focus on and embed actions that progress priorities within NSW Future Health and Regional Health Strategic Plans. This includes focus on priority population groups including Aboriginal people, older people, pregnant women and children, as well as improving the health and wellbeing of communities through prevention, early intervention and addressing the social determinants of health, in partnership with other agencies and organisations. There will also be a focus on being responsive and agile to changes in health, social and environmental risks which impact NNSWLHD communities and services.

Table 1: Priority Focus Area - Overview

| Priority | Overview |
|---|---|
| Clinical streams | Reviewing the governance and operations of clinical services across the LHD, and streaming a greater number of clinical services, will deliver improvements in equitable access to care, staff and patient experience, and efficient use of resources. This approach will also support the delivery of coordinated and consistent approaches to clinical care, with a focus on safe and high-quality outcomes. |
| Role of facilities | The LHD currently operates eight hospitals, four MPSs, three HealthOnes and 17 community health centres. To support efficiency, future sustainability, and the ability to deliver 'right care, right time, right place, right clinician', the role of facilities, along with partnerships and models of care, needs to be considered in a contemporary way. This will support improvements in patient care access and outcomes, and will also encourage innovation and contemporary models, making NNSWLHD a more attractive place to work. |
| Ambulatory care | Delivering more care outside of acute hospital settings will support improvements in access to care and patient experience of care. This priority will focus on partnership approaches supporting sustainable service delivery to meet patient, carer and clinician needs. |
| Vulnerable clinical services | Sustainable service delivery that meets population need is a key focus for NNSWLHD. The LHD will consider the viability of services, including those that require further resourcing to meet demand, and those that do not have the population base to sustain ongoing service delivery. This priority is closely aligned with, and will support, the streaming services and role of facilities priorities. |
| Empowering Aboriginal health | Improving health outcomes for the LHD's Aboriginal population is a key priority, and one which also underpins and is embedded in all priority areas. There are several areas of focus to empower Aboriginal people to take control of their own health and wellbeing, as well as in improving service delivery with respect to cultural safety and creating environments that Aboriginal patients, consumers, family and carers are comfortable and confident to access. |

| Priority | Overview |
|---|---|
| Care for older people | As a large and growing population group, implementing best-practice and contemporary models of care and approaches to service delivery for older people will help to keep people well and supported in the community, and ensure that hospital stays are appropriate and deliver high-quality and high-value care. |
| Mental health and alcohol and other drug services | People experiencing mental health and/or AOD-related illness are more likely to develop comorbid physical illness, be hospitalised for preventable reasons, and have a higher mortality rate. They also experience more barriers to accessing healthcare services than the general population and experience stigma and discrimination. People living in NNSWLHD report higher levels of psychological distress, have higher rates of hospitalisation for mental health and AOD-related conditions, and higher rates of suicide, than their metropolitan counterparts. There is also poorer access to mental health services, which can create further disparities in health and wellbeing outcomes. There are opportunities to strengthen access to the right care through service models, partnership approaches, providing more care in ambulatory settings, and a focus on early intervention. |

The staging or timing of actions outlined in each Priority Focus Area have been considered across three phases:

- Phase 1: mid-2024
- Phase 2: mid-2024 to mid-2026
- Phase 3: mid-2026 onwards

## 2.2 Priority Focus Area: Clinical streams

### 2.2.1 Priority at a glance

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| Overview | Reviewing the governance and operations of clinical services across the LHD, and streaming a greater number of clinical services, will deliver improvements in equitable access to care, staff and patient experience, and efficient use of resources. This approach will also support the delivery of coordinated and consistent approaches to clinical care, with a focus on safe and high-quality outcomes. |
| Strategic alignment – Future Health and Regional Health Plan | See appendices D and E. |
| Strategic alignment – other state-wide policies, plans, guidelines | NSW Health Workforce Plan 2022-2032 |
| Value based health care | • Improved efficiency and effectiveness of care by confirming standards and increasing consistency across the LHD (including a focus on reducing low value care), improved governance and performance management, and enabling greater budgetary engagement.<br>• Improved experience of providing care by increasing collaboration across sites, raising clinicians' voices, providing career pathways, and clearer clinical guidelines at the LHD level.<br>• Improved experiences of receiving care through clinical expertise and resources allocated effectively across the LHD, efficient inter-facility transfers, and improved access to local centres of excellence.<br>• Health outcomes that matter to patients through benchmarking, tracking and reporting on health safety and quality measures at the site and LHD levels. to identify improvement areas. |
| Relevant LHD plans | • NNSWLHD Surgical Services Plan (in development).<br>• Related Capital Investment Proposals (outlined in Capital section). |
| Planning assumptions or external interdependencies | • Support of industrial bodies and staff.<br>• Workforce recruitment and retention to key lead and support positions, supported by improved recruitment and onboarding processes.<br>• Adequate funding. |
| Target population | Whole of population. |

### 2.2.2 Case for change

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| Problem/opportunity | The current operational and governance structure of clinical services in the LHD is a mix of both clinical streams which span the LHD, and clinical networks which tend to operate within geographic boundaries. Clinical models which are currently operating only at a facility level or within a geographic location (e.g., Tweed Valley or Clarence Valley) can lead to disparities in patient access to |

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| | care, inconsistencies in service delivery and models of care, variation in skills and experience (e.g., due to low volume service in one location), and operational inefficiency. |
| Objectives | Establishing a greater number of clinical streams in NNSWLHD aims to:<br>• bring together and coordinate related specialties and/or services.<br>• strengthen multidisciplinary leadership and governance models.<br>• improve equitable access to services for patients, regardless of where they live.<br>• improve patient safety and quality outcomes.<br>• create efficiencies through shared resources and workload (e.g., shared workforce models, reduced duplication).<br>• create consistency in patient care models and pathways.<br>• create a shared vision for clinical service delivery.<br>• raise the voice of clinicians in the design and delivery of care and decision-making related to their services.<br>• improve opportunities for clinician education, training and maintaining recency of practice and levels of competence.<br>• support improved collaboration between clinical services and health promotion teams to deliver early intervention programs.<br>• support accreditation processes through improved consistency. |
| Service change (actions) and timeframes | In the short-term, to establish and implement clinical streams, the following will be undertaken:<br>• review of best practice models and streams operating in other LHDs, jurisdictions and internationally (Phase 1, by mid-2024).<br>• informed by stakeholder mapping and analysis, undertake a broad consultation and engagement approach across NNSWLHD (Phase 1, by mid-2024).<br>• development of a stream model and operational framework suited to NNSWLHD (Phase 1-2, mid-2024 to mid-2026).<br>• realignment of workforce to support stream functioning (e.g., FTE, activity/budget) (Phase 1-2, mid-2024 to mid-2026).<br>• staged approach to implementation of clinical streams (Phase 1-2, mid-2024 to mid-2026).<br>In the medium- to longer-term, there are opportunities to consider:<br>• devolved approaches to activity and financial management, aligned with clinical streams (this may be dependent on performance, assessment of impact, further benefit and efficiencies to be realised) (Phase 3, mid-2026 onward). |
| Outputs | A clinical stream model is implemented, including:<br>• stream clinical leads in place, with multidisciplinary engagement.<br>• stream plans/strategies developed, including areas of focus and future priorities.<br>• realignment of workforce and activity (as required).<br>• new and/or realigned FTE to support stream functioning. |

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| | • shared workforce models.<br>• governance structures in place.<br>• forward planning for infrastructure and recruitment. |
| Benefits/outcomes | • Improved patient access to safe, high-quality and high-value care.<br>• Improved patient experience and outcomes of care (e.g., measured through standardised collection and reporting of PRMs).<br>• Improved equity of access for at-risk and/or vulnerable population groups (e.g., Aboriginal population, geographically isolated communities).<br>• Increased cultural safety for Aboriginal population.<br>• Greater consistency, collaboration and networking across the LHD.<br>• Improved efficiency and service sustainability.<br>• Improved ability to attract and retain workforce.<br>• Improved workforce culture and engagement.<br>• Opportunities for research and university partnerships. |

### 2.2.3 Service model

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| Service model | • Service change and model is outlined in the above section.<br>• Clinical streams will be developed for NNSWLHD with consideration given to other LHD (e.g., Sydney and South Eastern Sydney) and jurisdiction (e.g., Mater Health QLD) models. |
| Illness prevention, health promotion, population health, early intervention | • New opportunities for services/programs may be identified once streaming services are identified and actioned.<br>• Clinical streams will take a whole of health approach including primary care and post-discharge care.<br>• Enhanced opportunities for clinician referrals into health promotion and prevention programs (particularly for those at risk) through improved consistency and coordination in clinical streams and models of care. |
| Out-of-hospital care | • New models of care that reduce the need for hospital stays.<br>• Greater utilisation of virtual patient interactions (consultations). |
| Virtual care | • Virtual LHD-wide Patient Flow and bed management.<br>• Virtual patient interactions (consultations).<br>• Inter-hospital care planning and coordination.<br>• Inter-health service care planning and coordination. |
| Role delineation | **Changes to role delineation:** Potentially<br>**Outline:** Once clinical streams are identified and actioned, role delineation at some hospitals may increase or decrease commensurate with the service re-organisation. |

## 2.3 Priority Focus Area: Role of facilities

### 2.3.1 Priority at a glance

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| Overview | The LHD currently operates eight hospitals, four MPSs, three HealthOnes and 17 community health centres. To support efficiency, future sustainability, and the ability to deliver 'right care, right time, right place, right clinician, right information', the role of facilities, along with partnerships and models of care, needs to be considered in a contemporary way. This will support improvements in patient care access and outcomes, and will also encourage innovation and contemporary models, making NNSWLHD a more attractive place to work. |
| Strategic alignment – Future Health and Regional Health Plan | See appendices D and E. |
| Strategic alignment – other state-wide policies, plans, guidelines | • NSW Health 20-Year Infrastructure Strategy<br>• NSW Health Facility Planning Process<br>• eHealth Strategy for NSW Health 2016-2026<br>• NSW Health Workforce Plan 2022-2032 |
| Value based health care | • Service efficiency, effectiveness and sustainability through ensuring clear roles for each facility and focusing resources where they are needed.<br>• Improved experience of providing care by providing staff with clear purpose and future direction of their facilities and services, and optimising service scope, capacity and/or capability at identified facilities.<br>• Improved experiences of receiving care at possible Centres of Excellence and through formalising patient transfer processes for inter-LHD and cross border.<br>• Health outcomes that matter to patients through benchmarking, tracking and reporting on health safety and quality measures at the facility and LHD levels to identify improvement areas that will drive better health outcomes. |
| Relevant LHD plans | • NNSWLHD Surgical Services Plan (in development).<br>• Ballina District Hospital CSP (draft)<br>• Clarence Valley CSP<br>• Related Capital Investment Proposals (outlined in Capital section). |
| Planning assumptions or external interdependencies | • Support of industrial bodies and staff.<br>• Workforce recruitment and retention to key lead and support positions (for new and enhanced services), supported by improved recruitment and onboarding processes.<br>• Other health services in NSW/QLD, non-government and private sectors are open to exploring partnerships to address key service gaps.<br>• Adequate funding. |
| Target population | Whole of population. |

### 2.3.2 Case for change

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| Problem/opportunity | There is recognition that not all services can be delivered at all facilities. This is for a range of reasons, including physical resources and infrastructure, workforce availability, efficiencies, and for safety and quality outcomes. While this is a clear and well-documented approach to health system management, there is currently ambiguity in facility roles in NNSWLHD, and this can create inefficiencies; sub-optimal patient care, outcomes and experience; and reductions in staff experience and culture. There are opportunities for NNSWLHD to drive value-based care through optimising the mix and delivery of services across facilities, including in ambulatory and community settings and through partnership models with other service providers (e.g., primary care and non-government organisations (NGOs)). |
| Objectives | The objectives of this Priority are to:<br>• improve patient access to the right care in the right place.<br>• enhance the delivery of contemporary and evidence-based models of care and therapies.<br>• reduce inefficiencies and inconsistencies in service delivery and patient pathways.<br>• identify models which are already in place and demonstrating effectiveness and embed and scale these where appropriate.<br>• improve linkages between hospital, community and other health services.<br>• provide staff with clear purpose and future direction of the facilities and services they work in and deliver.<br>• improve patient, carer and staff experience and outcomes.<br>• support the prioritisation of capital and infrastructure investment.<br>• collaborate with partners to improve health literacy in the community and ensure that a health literacy environment is considered when planning new or redesigning existing services. |
| Service change (actions) and timeframes | Informed by engagement with key stakeholders, undertake a review of facility roles, functions and networks across NNSWLHD to inform decisions and implementation of recommended service change which may include:<br>• confirming and/or optimising service scope, capacity and/or capability at identified facilities.<br>• identification of service specialisation and possible Centres of Excellence.<br>• implementing new and/or changed network and patient pathway, referral and transfer processes (within NNSWLHD).<br>• implementing new and/or changed patient referral pathways into community, primary and home-based care following presentation or admission to a NNSWLHD facility (within and external to NNSWLHD).<br>• formalising patient transfer processes for inter-LHD and cross-border. |
| Outputs | • Articulation of the current and future role of facilities, networks and referral pathways. This may be delivered in detailed clinical stream or specialty-specific service plans, completion of the NNSWLHD Surgical Services Plan, and may include delivery of Centre of Excellence models.<br>• Delivery of committed capital investments, including the new Tweed Valley Hospital and redeveloped Grafton Base Hospital.<br>• Delivery of planned services at new and redeveloped facilities. |

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| | • Development of service specialisation in facilities where there is population need and/or can deliver efficiencies and improved outcomes for patients and staff. |
| Benefits/outcomes | • Improved patient flow between NNSWLHD facilities, for example:<br>— reduced length of stay for inpatients awaiting transfer to another NNSWLHD facility.<br>• Improved patient safety and quality outcomes, for example:<br>— reduced rates of hospital acquired complications.<br>— reduced unplanned hospital readmissions.<br>• Increased uptake of virtual care models, shown through an increase in non-admitted services provided through virtual care.<br>• Improved staff culture and experience, for example, improved ratings in the 'role clarity and support' questions in the People Matter Employee Survey.<br>• Improved patient experience and outcomes of care (e.g., measured through standardised collection and reporting of PRMs).<br>• Improved community awareness of NNSWLHD facilities and services, including communication of the 'right care, right time, right place, right clinician, right information' principle. |

### 2.3.3 Service model

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| Service model | • Service change and model is outlined in the above section.<br>• A review of best practice, local service data (e.g., historical and projected activity) and other data and information sources (e.g., population projections, local council planning) is to be undertaken to inform this priority. |
| Illness prevention, health promotion, population health, early intervention | • New opportunities for services/programs may be identified once roles of facilities are confirmed and actioned. |
| Out-of-hospital care | • Greater utilisation of virtual patient interactions (consultations).<br>• Remote patient monitoring, assessment and diagnosis.<br>• Greater utilisation of Hospital in the Home (HITH). |
| Virtual care | • Virtual LHD-wide Patient Flow and bed management.<br>• Virtual patient interactions (consultations).<br>• Inter-hospital care planning and coordination.<br>• Increased utilisation of virtual health at peripheral sites. |
| Role delineation | **Changes to role delineation:** Potentially<br>**Outline:** Once roles of facilities are identified and actioned, role delineation at some hospitals may increase or decrease commensurate with the service re-organisation. Role delineation will remain up to Level 5 only at Tweed Valley Hospital and Lismore Base Hospital. |

## 2.4 Priority Focus Area: Ambulatory care

### 2.4.1 Priority at a glance

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| Overview | Delivering more care outside of acute hospital settings will support improvements in access to care and patient experience of care. This priority will focus on partnership approaches supporting sustainable service delivery to meet patient, carer and clinician needs. |
| Strategic alignment – Future Health and Regional Health Plan | See appendices D and E. |
| Strategic alignment – other state-wide policies, plans, guidelines | • NSW Health Guideline: Management of Outpatient (Non-Admitted) Services |
| Value based health care | • Efficiency and effectiveness of care by providing more services out-of-hospital, avoiding hospitalisations and partnering with key stakeholders.<br>• Improved experience of providing care by implementing a strategic, coordinated and enhanced approach, and supporting clinicians to work to the top of their scope.<br>• Improved experiences of receiving care by increasing integrated access to services, including through virtual care where appropriate.<br>• Improvement in health outcomes that matter to patients through increasing service access, delivering local Leading Better Value Care (LBVC) programs (e.g., osteoporosis refracture prevention), and enhancing data collection and reporting to better benchmark and identify improvement areas (e.g., Patient Reported Measures (PRMs)). |
| Relevant LHD plans | • Clarence Valley CSP<br>• Ballina District Hospital CSP (draft)<br>• Related Capital Investment Proposals (outlined in Capital section). |
| Planning assumptions or external interdependencies | • Workforce recruitment and retention to key lead and support positions, supported by improved recruitment and onboarding processes.<br>• Other health services in NSW/QLD, NGO and private sectors are open to exploring partnerships to address key service gaps.<br>• Adequate funding.<br>• Funding structures which support care delivery in ambulatory settings and reductions in hospital admissions. |
| Target population | • Whole of population.<br>• Focused strategies and actions for at-risk and vulnerable population groups including those at risk of hospitalisation and at-risk children and families to support prevention approaches.<br>• Programs specific to the Aboriginal population are outlined in the 'Empowering Aboriginal Health' priority. |

## 2.4.2 Case for change

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| Problem/opportunity | Better access to safe, high quality and timely health services can be supported through effective provision of out-of-hospital services (community health, outpatient clinics, oral health, virtual services and HITH). These support system efficiencies by reducing potentially preventable hospitalisations, unplanned hospital readmissions and reducing the length of hospital stays. There are also opportunities to reduce the likelihood and impact of health concerns impacting NNSWLHD communities through focusing on prevention, early intervention and addressing modifiable risk factors. |
| Objectives | • Deliver appropriate services in the community that provide more sustainable solutions for equitable access to health care closer to home and effectively bridge the gap with inpatient care.<br>• Identify models which are already in place and demonstrating effectiveness and embed and scale these where appropriate.<br>• Improve integrated and coordinated service delivery across the life course and healthcare spectrum, including with a focus on delivering joint initiatives with Healthy North Coast.<br>• Leverage virtual care to improve access, whilst ensuring cultural and digital barriers are addressed.<br>• Drive and support improved clinical care, timely access and safety and quality outcomes for patients in community and outpatient settings.<br>• Increase delivery of evidence-based health promotion and prevention strategies into ambulatory care services and ensure that clinicians are equipped with resources and training to meet the demands of the community, including in emerging population health trends.<br>• Align infrastructure and sustainable service planning around the needs of staff and communities and to enable virtual care. |
| Service change (actions) and timeframes | • Develop and implement NNSWLHD Out-of-Hospital Care Strategy aimed at increasing services, health promotion, providing greater support, and improving efficiency, access and patient experience in outpatient and community settings. (Phase 2 – end 2024)<br>• Identify and influence high priority service gaps for co-commissioning with Healthy North Coast and other partners. (Phase 1 – mid 2024)<br>• Increase services in community health to reduce hospitalisation, including targeting improvement opportunities identified from local LBVC programs such as knee and hip arthritis service and osteoporosis refracture prevention. (Phase 2 – end 2024)<br>• Develop and implement NNSWLHD Allied Health Workforce Plan that aims to increase student placements, new graduate positions and support clinicians to work at the top of their scope. (Phase 2 – end 2024)<br>• Increase virtual care utilisation through ongoing implementation of the NNSWLHD Virtual Care Strategy 2021-2026. (Phase 2 – end 2024)<br>• Increase provision of, and access to, integrated outpatient services for children with behavioural and developmental concerns, subject to availability of additional funding. (Phase 2-3 – 2026)<br>• Adopt hub-and-spoke models with other health services to access specialist input in outpatient and community health settings where the position is unavailable locally. (Phase 2-3 – 2026).<br>• Explore and advocate for additional urgent care services across the NNSWLHD footprint. (Ongoing). |

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| Outputs | • Increases in non-admitted patient activity.<br>• Operationalisation of expanded ambulatory care services across NNSWLHD including at the new Tweed Valley Hospital and IACC at Ballina District Hospital (subject to redevelopment).<br>• Operationalisation of Urgent Care Centre service in Tweed Heads.<br>• New infrastructure delivered including the Urgent Care Centre and IACC at Ballina District Hospital (subject to redevelopment).<br>• Greater consistency of services across NNSWLHD. |
| Benefits/outcomes | • Accessible and equitable services delivered closer to home or in home.<br>• Improved patient experience and outcomes of care (e.g., measured through standardised collection and reporting of PRMs).<br>• Greater coordination, integration and continuity of care.<br>• Reduced demand on acute services through a reduction in unplanned readmissions and avoidable hospital presentations.<br>• Improved service and workforce efficiency and sustainability.<br>• Improved health and wellbeing outcomes for at-risk groups through a focus on prevention, early intervention and a life course approach (e.g., meeting the needs of children with behavioural and developmental concerns and disorders is a key aspect of managing future demand for mental health, alcohol and other drug services). |

### 2.4.3 Service model

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| Service model | • Service change and model is outlined in the above section.<br>• Hospital avoidance – Evidence base here.<br>• Virtual Care – Evidence base here.<br>• Hub and Spoke Model<br>• Urgent Care Service – Evidence base here. |
| Illness prevention, health promotion, population health, early intervention | • Strengthen referral pathways between clinical services and local health promotion and healthy lifestyle programs.<br>• Enhance outreach services to support access in hard-to-reach and vulnerable communities and populations.<br>• Increase services in community health to reduce hospitalisation, including targeting improvement opportunities identified from local Leading Better Value Care programs such as high-risk foot and osteoporosis refracture prevention. |
| Out-of-hospital care | • Increase services in community health to reduce hospitalisation.<br>• Increase services in community health to reduce the likelihood and impact of future acute and chronic health conditions, particularly in at-risk and vulnerable cohorts (e.g., children with behavioural and developmental concerns or disorders).<br>• Increase outpatient clinics for preoperative pre-habilitation and postoperative care programs. |

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| | • Greater utilisation of virtual patient interactions (consultations) when appropriate.<br>• Greater utilisation of HITH. |
| Virtual care | • Virtual pre- and post-hospital patient interactions (consultations), care planning and coordination and clinical collaboration (in Community Health Services and Outpatient Clinics).<br>• Potential to explore virtual care models to support alternatives to ED presentation/hospital avoidance. |
| Role delineation | **Changes to role delineation:** No<br>**Outline:** Service changes will remain within current role delineation. |

## 2.5 Priority Focus Area: Vulnerable clinical services

### 2.5.1 Priority at a glance

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| Overview | Sustainable service delivery that meets population need is a key focus for NNSWLHD. The LHD will consider the viability of services, including those that require further resourcing to meet demand, and those that do not have the population base to sustain ongoing service delivery.<br>This priority is closely aligned with, and will support, the streaming services and role of facilities priorities. |
| Strategic alignment – Future Health and Regional Health Plan | See appendices D and E. |
| Strategic alignment – other state-wide policies, plans, guidelines | • N/A |
| Value based health care | • Efficiency, effectiveness and sustainability of care by considering services from a population-based planning lens. This will shift focus from volume to value and better focus resources where they are needed, including through options for partnering with other providers to deliver services.<br>• Improved experience of providing care by aligning resourcing to meet patient demand and improve service viability where required.<br>• Improved experiences of receiving care through improved access and reduced wait times for in-demand services.<br>• Health outcomes that matter to patients through benchmarking, tracking and reporting on health safety and quality measures at the facility and LHD levels to identify improvement areas that will drive better health outcomes. |
| Relevant LHD plans | • NNSWLHD Strategic Plan 2019-2024 |
| Planning assumptions or external interdependencies | • Up-to-date and reliable data sources including internal NSW Health data and external sources.<br>• The identification of an evidence-based and suitable population-based clinical service planning methodology is available.<br>• Support of industrial bodies and staff.<br>• Workforce recruitment and retention to key lead and support positions (for new and enhanced services), supported by improved recruitment and onboarding processes.<br>• Other health services in NSW/QLD, non-government and private sectors are open to exploring partnerships to address key service gaps.<br>• Adequate funding. |
| Target population | • Whole of population |

### 2.5.2 Case for change

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| Problem/opportunity | There are several current and future pressures that will impact on the sustainability of health service delivery in NNSWLHD, including an ageing population, increases in people with chronic and complex conditions, rising costs and workforce recruitment and retention challenges. There are opportunities to reconsider what services are delivered, how they are delivered (e.g., service and workforce models), where they are delivered, what patient need they are meeting, and what outcomes they are achieving. By considering services from a population-based planning lens, the LHD will be able to review service viability and better focus resources where they are needed. |
| Objectives | The objectives of this priority are to:<br>• improve service and financial sustainability.<br>• ensure a focus on safe, high-quality and high-value care.<br>• deliver services based on population need rather than the more traditional service model, e.g.:<br>— identify required services for the NNSWLHD population that are currently operating unsustainably (e.g., due to workforce) and focus on improving the viability of the service; and<br>— identify services that are not viable to sustain based on low population need and/or population size. |
| Service change (actions) and timeframes | The priority will:<br>• undertake a range of stakeholder engagement and analysis to identify local services that are vulnerable (e.g., not operating a viable or sustainable service model). This may be due to inadequate workforce, insufficient cases to maintain safe practice, or other resourcing to meet population need.<br>• undertake population-based planning to establish the mix and level of services that are required to be delivered by NNSWLHD to meet population need and improve health outcomes, now and into the future.<br>• redirect resources to align with service need.<br>• scope the potential for enhanced partnership models for service delivery in instances where NNSWLHD cannot viably deliver a service. |
| Outputs | The realignment of services to population need will deliver:<br>• increased investment and activity in services with high population need that are currently under-resourced.<br>• reduced or ceased activity in services where there is low population need and the service is more appropriately delivered through a partnership model (e.g., other LHD, cross-border, primary care) or hub-and-spoke model (e.g., with other LHD).<br>• reduced wait list times for in-demand services.<br>• targeted workforce recruitment for in-demand services.<br>• consideration of alternative workforce models that would support NNSWLHD to meet demand, including in nurse or allied health led service models, or changes to scope of practice. |
| Benefits/outcomes | • Improved patient access to in-demand services which are currently under-resourced, e.g., geriatric services. This may be realised through a reduction in waiting lists/wait times for outpatient appointments, or reduced length of stay in hospital. |

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| | • Improved patient experience resulting from better access to care.<br>• Improved service sustainability:<br>— identified required services are operating a viable workforce and service model, e.g., high demand services have >1 FTE medical staff and have appropriate levels of nursing, allied health and administrative support to operate efficiently.<br>— enhanced partnership models implemented.<br>— increased uptake of virtual care models.<br>• Improved staff experience.<br>• Future service planning is supported by a robust, population-based approach which considers ongoing service sustainability in initial planning phases, therefore reducing vulnerability once in operation. |

### 2.5.3 Service model

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| Service model | • Service change and model is outlined in the above section.<br>• The service model will shift to a focus on population need and establishing thresholds for service delivery (e.g., critical mass).<br>• A review of best practice and high-quality evidence is to be undertaken to inform this priority. |
| Illness prevention, health promotion, population health, early intervention | • New opportunities for services/programs may be identified once vulnerable clinical services are further resourced or discontinued. |
| Out-of-hospital care | • Greater utilisation of virtual patient interactions (consultations).<br>• Remote patient monitoring, assessment and diagnosis.<br>• Greater utilisation of HITH. |
| Virtual care | • Peripheral hospital emergency department and other clinical service virtual patient interactions (consultations).<br>• Remote patient monitoring, assessment and diagnosis. |
| Role delineation | **Changes to role delineation:** Potentially.<br>**Outline:** Once vulnerable clinical services are identified and actioned, role delineation at some hospitals may increase or decrease commensurate with the service re-organisation. Role delineation will remain up to Level 5 only at Tweed Valley Hospital and Lismore Base Hospital. |

# 2.6 Priority Focus Area: Empowering Aboriginal Health

## 2.6.1 Priority at a glance

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| Overview | Improving health outcomes for the LHD's Aboriginal population is a key priority, and one which also underpins and is embedded in all priority areas. There are several areas of focus to empower Aboriginal people to take control of their own health and wellbeing, as well as in improving service delivery with respect to cultural safety and creating environments that Aboriginal patients, consumers, family and carers are comfortable and confident to access. |
| Strategic alignment – Future Health and Regional Health Plan | See appendices D and E. |
| Strategic alignment – other state-wide policies, plans, guidelines | • NSW Aboriginal Health Plan 2013-2023<br>• NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool GL2020_006<br>• NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025 |
| Value based health care | • Improve Aboriginal people's experiences of receiving care through delivering culturally safe environments and programs, locally relevant health information, and improved access, equity and supported decision-making throughout the health journey.<br>• Improve patient outcomes through delivering Aboriginal-specific programs and services that will improve access, and enhanced reporting of Aboriginality will support targeted approaches to improving care outcomes.<br>• Improve the experience of delivering care through growing and supporting the LHD's Aboriginal workforce, having culturally safe working environments, and strengthening relationships across the LHD.<br>• Drive improved effectiveness and efficiency through collaborative and integrated approaches and enhanced data collection and reporting to support decision-making. |
| Relevant LHD plans | • NNSWLHD Aboriginal Health Action Plan 2021-2026<br>• NNSWLHD Innovate Reconciliation Action Plan October 2021 – October 2023<br>• NNSWLHD Strategic Plan 2019-2024<br>• Ballina District Hospital CSP (draft)<br>• Related Capital Investment Proposals (outlined in Capital section). |
| Planning assumptions or external interdependencies | • Aboriginal workforce recruitment and retention, supported by improved recruitment and onboarding processes.<br>• Other non-government and private health services providers are open to exploring partnerships to address key service gaps.<br>• Adequate funding. |
| Target population | • Aboriginal people and communities across NNSWLHD.<br>• Staff who identify as Aboriginal or Torres Strait Islander. |

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| | • Targeted population-based programs, including for Aboriginal men's health, women's health, older persons, early engagement with children and youth, and broader health education programs (e.g., exercise and healthy eating).<br>• This priority will have a focus on priority interventions as well as priority populations (e.g., chronic renal, cardiac and respiratory disease, cancer and diabetes). |

### 2.6.2 Case for change

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| Problem/opportunity | The NNSWLHD population has a higher percentage of Aboriginal people compared to the NSW and national average. It is well evidenced that Aboriginal people face challenges in accessing safe and culturally appropriate healthcare and also experience disparities in health status and outcomes. Over many years, NNSWLHD has made significant progress toward the delivery of culturally appropriate services, yet more can be done to assist and empower Aboriginal people to become stronger and more confident in having control over their own health and feeling safe to access all the LHD's services. |
| Objectives | • Strengthening and growing the LHD's Aboriginal workforce.<br>• Enhancing partnerships.<br>• Providing culturally safe environments.<br>• Ensuring seamless planning and service delivery.<br>• Improved reporting.<br>• Focus efforts on working in partnership with LHD Aboriginal workforce, AMSs and other relevant services and agencies to deliver evidence-based programs to improve the health, wellbeing and healthy literacy of Aboriginal people.<br>• Increase Aboriginal and Torres Strait Islander supplier diversity. |
| Service change (actions) and timeframes | Strengthening and growing the LHD's Aboriginal workforce:<br>• Prioritise Aboriginal workforce recruitment, retention and development model will aim to increase Aboriginal employment, mentoring, networking and skill development opportunities, as well as address barriers to workforce participation (with a focus on facilities where Aboriginal staff are underrepresented).<br>• Strengthen partnerships with local Aboriginal-controlled health organisations on training and research initiatives to build workforce capacity.<br>Enhancing partnerships:<br>• Strengthening relationships, governance structures and working collaboratively across all NNSWLHD Directorates to empower Aboriginal health, and provide forums where partners consult, provide advice and negotiate on matters relevant to Aboriginal health.<br>• Form the Ngayundi Aboriginal Health Council Executive Advisory Group.<br>• Implement additional initiatives aimed at addressing social determinants of health and keeping people healthy and out of hospital through new, integrated and shared care models in collaboration with local Aboriginal-controlled health organisations and other key partners.<br>• Improve engagement with Aboriginal communities in the planning, delivery, monitoring and evaluation of health services. |

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| | • LHD facilities to complete the NSW Health Services Aboriginal Cultural Engagement Self-Assessment Audit Tool annually.<br>• Continue to facilitate the Aboriginal Health Impact Statement (AHIS) process, align local processes with the NSW Health Policy Directive, and provide staff education.<br>Providing culturally safe environments:<br>• Continue engagement and consultation with local Aboriginal people in capital infrastructure projects.<br>• Promote and implement the Respecting the Difference Framework online and face-to-face training.<br>• Develop locally relevant health information for Aboriginal communities and deliver physical environments that are community-informed and culturally safe.<br>• Develop, implement and review the NNSWLHD Reconciliation Action Plan (RAP) under the guidance of Reconciliation Australia.<br>• Aboriginal specific health information is adapted/developed locally and provided to Aboriginal patients and clients, and their carers and families.<br>• Review and improve Aboriginal patient identification practices and provide staff education.<br>Ensuring seamless planning and service delivery:<br>• Undertake a review of Aboriginal people's utilisation of local health service-related travel to identify actions to improve access to IPTAAS and other transport options.<br>• Strengthen the provision of and increase resources for health education, health promotion, early intervention and chronic disease management with a focus on Aboriginal specific services for chronic renal, cardiac and respiratory disease, cancer and diabetes.<br>• Further develop, implement and evaluate population-based targeted and health education programs (with service partners where relevant).<br>• Establish culturally safe palliative and end of life care services.<br>Improved reporting:<br>• Develop the NNSWLHD Aboriginal Health Dashboard and report to the NNSWLHD Board, Executive Leadership Team, Tier 3 managers and the community (e.g., through the Community Partnership Advisory Council). |
| Outputs | Strengthening and growing the LHD's Aboriginal workforce:<br>• The LHD's Aboriginal workforce is at or above 5% with low turnover.<br>• Capability development and opportunities for career growth are in place.<br>Enhancing partnerships:<br>• Northern NSW Aboriginal Health Partnership in place.<br>• Aboriginal voices are embedded into all levels of the LHD's business, governance and consultative structures.<br>• Strong internal relationships to work towards culturally safe and respectful workplaces for Aboriginal patients, clients and staff.<br>• Strong health relationships with external agencies particularly Aboriginal Medical Services.<br>Providing culturally safe environments: |

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| | • Delivery of cultural education to staff to enhance culturally safe work environments and health services.<br>• Culturally safe services and initiatives are available.<br>• Improved access, equity and supported informed decision making at each stage of the health journey.<br>• Enhanced reporting of Aboriginality.<br>Ensuring seamless planning and service delivery:<br>• Population-based targeted programs are implemented, including men's health, women's health, older persons, early engagement with children and youth, and broader health education programs (e.g., exercise and healthy eating).<br>• Aboriginal specific services are implemented for chronic renal, cardiac and respiratory disease, cancer and diabetes.<br>Improved reporting:<br>• Timely data analysis, reporting, identification of improvement areas and development of improvement actions to improve outcomes for Aboriginal people. |
| Benefits/outcomes | • Cultural differences and strengths are recognised and responded to in the governance, management and delivery of health services across the LHD.<br>• Aboriginal patients, clients, their carers and families are informed and supported.<br>• Enhanced Aboriginal health and wellbeing through early intervention programs with children and youth with a focus on exercise, nutrition and tobacco/vaping cessation.<br>• Comprehensive chronic disease management support provided to registered Chronic Care for Aboriginal People (CCAP) program clients.<br>• Culturally safe palliative care and cancer services pathway in NNSWLHD.<br>• Reduced duplication and burden on patients, carers and families through stronger partnership approaches.<br>• Enhanced visibility of Aboriginal patient data to drive service improvement.<br>• Support improved economic and social outcomes. |

### 2.6.3 Service model

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| Service model | • Service change and model is outlined in the above section.<br>• Integrated Aboriginal Chronic Care Model – Evidence base here and here.<br>• Culturally safe palliative and end of life care – Evidence base here. |
| Illness prevention, health promotion, population health, early intervention | • Further develop, implement and evaluate Aboriginal specific services aimed at supporting healthy and safe lives from conception to end of life with a focus on first 2,000 days, child, youth and family health, and chronic disease management. |
| Out-of-hospital care | • Increase services in primary care sector in partnership with Aboriginal Medical Services and other primary care organisations.<br>• Increase services in community health to reduce hospitalisation. |

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| | • Increase outpatient clinics for preoperative pre-habilitation and postoperative care programs.<br>• Greater utilisation of virtual patient interactions (consultations) when appropriate.<br>• Greater utilisation of HITH. |
| Virtual care | • Enhancing virtual care partnerships with Aboriginal Medical Services and other primary care organisations to increase utilisation. |
| Role delineation | **Changes to role delineation:** No<br>**Outline:** Service changes will remain within current role delineation. |

# 2.7 Priority Focus Area: Care for older people

## 2.7.1 Priority at a glance

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| Overview | As a large and growing population group, implementing best-practice and contemporary models of care and approaches to service delivery for older people will help to keep people well and supported in the community, and ensure that hospital stays are appropriate and deliver high-quality and high-value care. |
| Strategic alignment – Future Health and Regional Health Plan | See appendices D and E. |
| Strategic alignment – other state-wide policies, plans, guidelines | • Ageing Well in NSW: Seniors Strategy 2021-2031.<br>• NSW Older People's Mental Health Services, Service Plan 2017–2027. |
| Value based health care | • Efficiency and effectiveness of care by tailoring health services to a large and growing population of high users of health services, increasing hospital avoidance services and partnering with key stakeholders.<br>• Improved experience of providing care by increasing the number of specialist roles that can support services and build expertise in general workforce.<br>• Improved experiences of receiving care through implementation of best practice and contemporary models of care and providing more care outside of hospital.<br>• Improvement in health outcomes that matter to patients through using data and information to drive decision-making, including the use of PRMs to best understand what matters to older patients. |
| Relevant LHD plans | • Clarence Valley CSP<br>• Ballina District Hospital CSP (draft)<br>• Tweed Valley Service Statement<br>• NNSWLHD Virtual Care Strategy 2021-2026<br>• Related Capital Investment Proposals (outlined in Capital section). |
| Planning assumptions or external interdependencies | • Workforce recruitment and retention to key lead and support positions, supported by improved recruitment and onboarding processes.<br>• Other health services in NSW/QLD, non-government and private sectors are open to exploring partnerships to address key service gaps.<br>• Some services are Commonwealth funded which can limit expansion of service (e.g., Dementia Outreach Service).<br>• Adequate funding.<br>• Challenges caring for complex multimorbid older people in the primary care setting.<br>• Bed pressures and staffing pressures in residential aged care facilities and staffing and package provision with home care package providers. |

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| Target population | • Older people aged ≥65 (non-Aboriginal).<br>• Aboriginal and Torres Strait Islander people aged ≥50 years. |

### 2.7.2 Case for change

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| Problem/opportunity | A focus on care for older people is driven by multiple factors, including:<br>• NNSWLHD has a higher proportion of older people, and the population is ageing at a greater rate than the NSW and national averages.<br>• Older people tend to be higher users of health services, meaning that the ageing population will drive service demand into the future. For example, in 2021, 25% of the NNSWLHD population were aged ≥65 years yet accounted for nearly 50% of overnight inpatient activity.<br>• Based on the Australian Government's aged care provision ratio, there is a current and projected future under-supply of aged care places across NNSWLHD. This has been exacerbated by the recent and impending closure of multiple residential aged care facilities in the region. Inadequate aged care availability can result in longer length of stay in hospital for older patients who are awaiting transition to residential aged care. NNSWLHD data shows that these patient numbers are increasing year-on-year.<br>• Consultation with clinical services across NNSWLHD indicates that older people are presenting with higher levels of comorbidity and functional decline than has been seen in the past.<br>• Specialist geriatric staffing is low, and coupled with high patient demand, makes services vulnerable. There is a lengthy wait to be seen in the single Geriatric Aged Care Clinic (>12 months). There is an opportunity to implement a geriatric model of care focused across the whole LHD to improve cohesive service provision across the continuum of care.<br>• There is opportunity to enhance care of older people experiencing geriatric syndromes such as falls, cognitive impairment, functional decline, frailty, sarcopenia, and incontinence.<br>• Increased implementation of, and access to, hospital avoidance strategies can reduce the challenges associated with older people entering hospital with complex multimorbidity.<br>• Increased demand for Commonwealth-funded care packages to support people in their own homes, resulting in increased wait times.<br>There are opportunities to reduce the impact of the ageing population on NNSWLHD's services. This will include implementing best practice and contemporary models of care, partnering with other government and NGOs, delivering care in the right settings, and focusing on keeping people healthy and well for longer. |
| Objectives | • Implement evidence-based strategies to promote healthy ageing and early intervention to support people to live more years in full health and independently at home.<br>• Develop and deliver best practice, contemporary, collaborative and integrated models of care for older people.<br>• Deliver more occasions of service across key services in community and outpatient settings.<br>• Enhance partnership approaches to older persons care for hospital avoidance and reduced length of hospital stays. |

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| | • Enhance engagement with non-health agencies that support healthy ageing and healthy community programs, including local Councils and community groups.<br>• Increased awareness of health promotion programs among LHD staff to strengthen referral pathways. |
| Service change (actions) and timeframes | • Develop the NNSWLHD Healthy Ageing and Falls Prevention Action Plan.<br>• Enhance and embed partnership approaches to older persons care, recognising that it is multifaceted and requires action from government, non-government and private entities.<br>• Introduce best practice, integrated, LHD-wide, contemporary and person-centred models of care, including but not limited to:<br>— Geriatric Evaluation and Management (GEM) Unit(s) at facilities where the model can be effectively implemented and adequately resourced. This would improve opportunities to rehabilitate older people in the hospitalised setting with a multidisciplinary approach early in their journey with the aim to transition to home-based services rather than residential aged care.<br>— Where a GEM Unit isn't appropriate, consider geriatric service access for the facility and/or catchment, including through networked and virtual options.<br>— Orthogeriatric / acute geriatric model of care to support acutely unwell older patients, with a particular focus on LBH.<br>— Dementia-specific care, including psychogeriatric models, considering the National Mental Health Service Planning Framework, Commonwealth initiatives/funding, primary care partnership and partnerships with other LHDs (e.g., virtual input from specialist psychogeriatricians in metro LHDs).<br>— Specialist geriatric-led and multidisciplinary (medical, nursing and allied health) in-reach to emergency departments.<br>— Geriatric consultation service at identified facilities (face-to-face and virtual).<br>— Increasing virtual care services for medical consultant, nursing and allied health models.<br>• Standardise the use of patient reported quality of life measures as part of integrated models of care for older persons.<br>• Enhance the provision and delivery of residential aged care through the MPS model. This will include ties to proposed capital investment (e.g., redevelopment of Urbenville MPS).<br>• Increase general community and outpatient services for older people and specialist aged care services such as dementia outreach, neuropsychology, aged care assessment, transitional aged care, Parkinson's Disease and expand the Geriatric Aged Care Clinic service (including for example, a virtual memory clinic). This may include through partnership approaches with primary care and NGOs.<br>• Explore options for promoting the uptake of specialist geriatric roles in the LHD, including the option of a new geriatric advanced trainee position.<br>• Explore integrated and coordinated care models for people in residential aged care settings, including in partnership with Healthy North Coast, to reduce unnecessary transfers to hospital (e.g., virtual care, in-reach and Nurse Practitioner models). |

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| | • Explore the establishment of a Community Geriatric Service team to provide care to complex older patients in the community and residential aged care settings.<br>• Implement the Enhanced Care Program across all facilities within NNSWLHD. |
| Outputs | • NNSWLHD Healthy Ageing and Falls Prevention Action Plan is implemented.<br>• Redeveloped Urbenville MPS (if funding committed) will meet design standards, support best practice and contemporary models of care, and adopt Aboriginal design principles for cultural safety.<br>• GEM unit(s)s are operational and data capture and coding is accurately reflecting service activity.<br>• Increased occasions of service for older persons in community and outpatient settings.<br>• Acute service activity for older patients does not increase at the same rate as population ageing.<br>• Psychotropic medicines in cognitive disability or impairment clinical care standard implementation. |
| Benefits/outcomes | • Reduced length of hospital stays for older patients, including those awaiting aged care placement.<br>• Reduction in avoidable or preventable ED presentations and hospital admissions for older people.<br>• Increased rates of discharge to the community setting from inpatient hospital admissions with increased community service provision.<br>• Adequately staffed and functioning GEM unit(s) to generate additional funds and improve outcomes for older people requiring hospitalisation, e.g., improvements in the functioning of older people with multidimensional health needs.<br>• Older people live active and healthy lives, with improved physical and mental wellbeing.<br>• Greater access to specialist services and best practice and contemporary models of care.<br>• LHD infrastructure meets the needs of older people, including culturally appropriate services for older Aboriginal people.<br>• Safe, inclusive, person-centred, multidimensional / multidisciplinary approach to assessment and care.<br>• Improved experience of care for older people accessing LHD services (e.g., evidenced through Bureau of Health Information survey program, disaggregated by age group).<br>• Over the longer-term, acute service activity for older people reduces as a proportion of the size of the population.<br>• Safe, inclusive and person-centred care.<br>• Reduction in Hospital Acquired Complications for older persons such as falls, deconditioning, malnutrition and delirium.<br>• Reduction in Hospital Associated Deconditioning of older persons such as reduced muscle strength, reduced mobility, incontinence, demotivation, pneumonia and delirium. |

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| | • Reduction in restrictive practices including the use of psychotropic medicines to management complex behaviours in the cognitively impaired older person. |

### 2.7.3 Service model

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| Service model | • Service change and model is outlined in the above section.<br>• GEM Units – Evidence base here.<br>• Orthogeriatric Model of Care – Evidence base here.<br>• Specialist in-reach to Emergency departments – Evidence base here.<br>• Virtual Care – Evidence base here.<br>• MPS Model – Evidence base here.<br>• Integrated and coordinated care models – Evidence base here. |
| Illness prevention, health promotion, population health, early intervention | • Strengthen referral pathways between clinical services and local healthy ageing and falls prevention programs.<br>• Establish dementia specific and movement disorder (e.g., Parkinson's disease) specific falls prevention programs.<br>• Greater engagement and collaboration with Healthy North Coast, local Councils and NGO partners for delivery of social healthy ageing programs, home-based services, and safe environments for older people. |
| Out-of-hospital care | • Increase services in community health to reduce hospitalisation, such as establishment of a robust Community Geriatric service.<br>• Multidisciplinary approach to Community Geriatrics services to support older people living in the community and community clinicians (e.g., GPs, ACAT, TCS, Dementia Outreach Service), working with complex multimorbid older people.<br>• Improved transition to RACF from hospital through adequately resourced teams.<br>• Increase Geriatric-led outpatient care for older Aboriginal people.<br>• Increase outpatient clinics for preoperative pre-habilitation and postoperative care programs.<br>• Greater utilisation of virtual patient interactions (consultations) when appropriate.<br>• Greater utilisation of HITH. |
| Virtual care | • Hospital avoidance initiatives.<br>• Virtual visitor and interpreter services.<br>• Virtual patient interactions (consultations).<br>• Virtual clinical collaboration.<br>• Independent medication reviews for NNSWLHD MPS residents. |
| Role delineation | **Changes to role delineation:** No<br>**Outline:** Service changes will remain within current role delineation. |

# 2.8 Priority Focus Area: Mental health and alcohol and other drug services

## 2.8.1 Priority at a glance

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| Overview | People experiencing mental health and/or AOD-related illness are more likely to develop comorbid physical illness, be hospitalised for preventable reasons, and have a higher mortality rate.7 They also experience more barriers to accessing healthcare services than the general population8 and experience stigma and discrimination.9 People living in NNSWLHD report higher levels of psychological distress, have higher rates of hospitalisation for mental health and AOD-related conditions, and higher rates of suicide, than their metropolitan counterparts.10 There is also poorer access to mental health services,11 which can create further disparities in health and wellbeing outcomes. There are opportunities to strengthen access to the right care through service models, partnership approaches, providing more care in ambulatory settings, and a focus on early intervention. |
| Strategic alignment – Future Health and Regional Health Plan | See appendices D and E. |
| Strategic alignment – other state-wide policies, plans, guidelines | • Strategic Framework for Suicide Prevention in NSW 2022-2027<br>• Living Well: A Strategic Plan for Mental Health in NSW 2014-2024<br>• NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025 |
| Value based health care | • Improved consumer experience through increased service delivery in non-hospital settings, integrated service delivery (e.g., through co-commissioning), and providing services specific to at-risk groups, such as youth and pregnant women.<br>• Improved outcomes that matter to consumers will be achieved through increased service delivery in specialised areas, the ability to access support and treatment in a range of therapeutic settings, introducing new models of care that will improve safety and quality of care, and utilising PRMs and consumer surveys to improve services.<br>• Experiences of providing care will be improved through increased ability to refer to services that meet consumer needs, as well as through growing the MH&AOD workforce. |

[7] Australian Institute of Health and Welfare, 'Physical health of people with mental illness' Web article: Physical health of people with mental illness - Australian Institute of Health and Welfare (aihw.gov.au) (accessed 08.01.24)

[8] Corscadden, L., Callander, E.J., & Topp, S.M. 'Disparities in access to health care in Australia for people with mental health conditions' (2019) *Australian Health Review* 43, 619-627: Disparities in access to health care in Australia for people with mental health conditions (csiro.au) (accessed 08.01.24)

[9] Australian Government, Department of Prime Minister and Cabinet, 'National Survey of Mental Health-Related Stigma and Discrimination' November 2022: National Survey of Mental Health Stigma and Discrimination (pmc.gov.au) (accessed 08.01.24)

[10] NSW Government, HealthStats NSW, 'Mental health': HealthStats NSW - Mental health (accessed 10.10.23)

[11] Mental Health Commission of NSW, 'Reporting on mental health and wellbeing in Regional NSW': Reporting on the mental health and wellbeing of Regional NSW - Nov 2022 -FINAL.PDF (nswmentalhealthcommission.com.au) (accessed 10.10.23)

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| | • Service efficiency, effectiveness and sustainability will be improved through enhancing integrated care, partnerships approaches (incl. co-commissioning), delivering more services in non-hospital settings, and trialling new models of care (e.g., Mental Health Short Stay Unit). |
| Relevant LHD plans | • NNSWLHD Strategic Plan 2019-2024 |
| Planning assumptions or external interdependencies | • Workforce recruitment and retention to key lead and support positions, supported by improved recruitment and onboarding processes.<br>• Other health services in NSW/QLD, non-government and private sectors are open to exploring partnerships to address key service gaps.<br>• Systems and structures in place to support potential co-commissioning, e.g., with Healthy North Coast.<br>• Adequate funding. |
| Target population | • Whole of population, along with targeted sub-groups at high risk, including children and young people, Aboriginal people, older people and LGBTIQ+. |

### 2.8.2 Case for change

| | |
|---|---|
| Problem/opportunity | Compared to NSW averages, NNSWLHD communities report higher levels of mental health and AOD-related health issues, which is reflected in health service use data. There is also growing demand projected for mental health and AOD services. People experiencing mental illness are more likely to develop comorbid physical illness, have higher mortality rates and report higher levels of substance use.[12] Consumers often experience challenges in mental health and AOD service access, including stigma, the separation of mental and physical health services, and poor service integration which can lead to people slipping through the gaps. The complexity of mental health consumer presentations and access to integrated services may also lead to sub-optimal care, including consumers spending long lengths of time in emergency departments.<br>Mental health and mental wellbeing is a very broad continuum and supporting people across this continuum and at different points of illness or care requirement, requires a systems-based and integrated approach with service partners to improve service access and outcomes, particularly for vulnerable and at-risk groups. |
| Objectives | A focus on mental health and AOD service delivery aims to:<br>• improve the integration of services across acute, sub-acute, and non-acute streams, as well as with primary and community-based service partners.<br>• enhance and expand service delivery in areas required by at-risk and vulnerable population groups.<br>• deliver recovery-oriented services that incorporate strong consumer and carer/family input.<br>• ensure that consumers are being assessed and treated in the most appropriate setting, including outpatient and community. |

[12] Australian Institute of Health and Welfare, 'Physical health of people with mental illness', Web article (8 Mar 2023): Physical health of people with mental illness - Australian Institute of Health and Welfare (aihw.gov.au) (accessed 23/10/23)

| | |
|---|---|
| | • support population-based personal, social and emotional wellbeing through investing in early intervention, prevention and health promotion strategies.<br>• improve outcomes and experience for consumers of mental health and AOD services.<br>• improve service amenity and functionality with a focus on the ability to deliver safe and contemporary care models. |
| Service change (actions) and timeframes | • Establish a youth AOD service (Phase 2 – end of 2024).<br>• Establish an AOD ambulatory withdrawal service (Phase 1 – 2024).<br>• Increase provision of, and access to, outpatient clinics for mental health and AOD (Phase 2 – 2025).<br>• Establish a perinatal AOD service (Phase 2 – 2024).<br>• Expand the peer workforce and specialised mental health and AOD nursing workforce (including nurse practitioners and educators) (Phase 1 & 2 – 2023/24).<br>• Deliver the joint Mental Health, AOD and Suicide Prevention Strategy with Healthy North Coast, including outlined options for co-commissioning of services (Phase 2 – 2025).<br>• Trial a mental health short stay unit model at Tweed Valley Hospital (Phase 2-3 – 2025-2026).<br>• Support integrated and partnership approaches to enhance focus on prevention and early intervention for physical and mental health, including early in the course of mental illness in children and young people and during transition when clients are stepping up or down levels of care.<br>• Explore the requirement and feasibility of establishing mental health ICU bed(s) for the northern part of the state (in partnership with MNCLHD, subject to available funds) (Phase 3 – 2026).<br>• Use of the National Mental Health Service Planning Framework to inform service change (ongoing). |
| Outputs | • Increased activity in non-admitted mental health and AOD streams.<br>• AOD youth service and ambulatory withdrawal operational.<br>• Perinatal AOD service operational.<br>• Trial of a mental health short stay unit model at Tweed Valley Hospital with clear KPI/evaluation measures established to allow review of the success of the model and its applicability elsewhere.<br>• Increased peer workforce FTE, including in emergency departments and in identified Aboriginal peer worker roles.<br>• Increased mental health and AOD specific nursing FTE, including nurse practitioners and nurse educators.<br>• Improved physical infrastructure in the Lismore Base Hospital mental health inpatient unit which delivers a structurally sound and a safe clinical environment (subject to funding). |
| Benefits/outcomes | • Improved access to acute and ambulatory mental health and AOD services, particularly for vulnerable, at-risk and priority population groups.<br>• Improved patient flow through introduction of new models of care and bed types (e.g., high dependency at the new TVH). |

| | |
|---|---|
| | • Greater integration and coordination with the primary and community care sectors.<br>• Reduced duplicative effort and efficiencies gained through service co-commissioning.<br>• Progress towards the Towards Zero Suicides initiatives.<br>• Improved consumer experience, e.g., evidenced through the Your Experience of Service survey.<br>• Meeting performance thresholds on Service Agreement KPIs, including emergency department extended stays, seclusion and restraint, post-discharge community care, readmission, patients absconding.<br>• Improved staff culture and wellbeing across mental health and AOD services. |

### 2.8.3 Service model

| | |
|---|---|
| Service model | • Service change and model is outlined in the above section.<br>• Establishment of specific models, such as ambulatory withdrawal and youth AOD services, will be informed by best practice and the available evidence-base, including NSW Health Clinical Guidance and relevant Fact Sheets. |
| Illness prevention, health promotion, population health, early intervention | • Continue delivering and developing routine and opportunistic physical health screening.<br>• Strengthen referral pathways to local health promoting interventions.<br>• Further build health promoting culture within services through policy and procedure. |
| Out-of-hospital care | • Increase services in community health and outpatient clinics to reduce hospitalisation.<br>• Greater utilisation of virtual patient interactions (consultations) when appropriate. |
| Virtual care | • Virtual patient interactions (consultations). |
| Role delineation | **Changes to role delineation:** Potentially.<br>**Outline:** A longer-term consideration of MHICU beds would require role delineation consideration. |

# 3

# Support and enabling functions

## 3.1 Capital requirements

Table 2 provides an overview of current capital and infrastructure priorities for NNSWLHD and will support the delivery of the seven Priority Focus Areas outlined in this Plan. Delivery of capital works is dependent upon funding commitments from the NSW Ministry of Health and/or NSW Government.

Table 2: Current capital and infrastructure priorities to support delivery of Priority Focus Areas

| PRIORITY | Clinical streams | Role of facilities | Ambulatory care | Vulnerable clinical services | Aboriginal health | Care for older people | Mental health & AOD |
|---|---|---|---|---|---|---|---|
| **Service expansion / redevelopment** | | | | | | | |
| GBH | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| BDH refurb (long-term greenfield) | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| MDH – CT | | ✓ | | ✓ | | | |
| GBH – SSU | ✓ | ✓ | | | ✓ | ✓ | ✓ |
| Staff accomm (priority – Grafton) | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| CDMH – ward conversion for RAC | | ✓ | | | ✓ | ✓ | |
| **Expansion and regulatory** | | | | | | | |
| LBH Stage 3D | | ✓ | | | | | |
| **Regulatory requirement for fit-for-purpose facility** | | | | | | | |
| Urbenville redevelopment | | ✓ | | | ✓ | ✓ | |
| MDH – acute ward refurb | | ✓ | | | | | |
| LBH – MH inpatient unit | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ |
| LBH – Crawford House | | ✓ | | | | | |

### 3.1.1 Rationale for capital requirements and optimisation of existing assets

Table 3: Current capital and infrastructure priorities to support delivery of Priority Focus Areas - rationale and optimisation of existing assets

| Rationale for capital requirements | Optimisation of existing assets |
|---|---|
| **GBH – deliver redevelopment** | |
| • Election promise with State Budget funds committed.<br>• Aged infrastructure impacts upon efficiencies and delivery of high-quality patient care.<br>• Hospital is reaching capacity with new services needed to meet the needs of the catchment population. The population is older and ageing, with high levels of socioeconomic disadvantage and a high Aboriginal population.<br>• Plans for service uplift will meet population need including implementing appropriate mental health spaces and models in ED, consultation liaison services, and increased community-based services (Clarence Valley CSP, pg., 56, 66). | • As outlined in the Clarence Valley CSP (pg., 6), enhancing and embedding network relationships with LBH will see assets optimised across the service network.<br>• Master planning for the GBH redevelopment includes retaining and refurbishing some infrastructure.<br>• Home-based models (e.g., HITH) and virtual care are supporting existing asset optimisation by freeing up capacity in physical clinics and services. |
| **BDH – short-term refurbishment to meet need; long-term view to redevelop greenfield** | |
| • Aged infrastructure impacts upon efficiencies and delivery of high-quality and contemporary models of patient care.<br>• Cost of continued maintenance is high.<br>• Some existing buildings do not comply with current planning regulations and health facility guidelines (e.g., minimum clearance width and accessibility).<br>• Capacity is constrained with an inability to expand required services to meet the needs of the growing catchment population.<br>• Current ambulatory care services are delivered by various units at BDH, creating inefficiencies, difficult patient access, and limited ability to deliver multidisciplinary care.<br>• More broadly across the LHD, there is a need to increase physical ambulatory care capacity to support patient access, particularly for vulnerable population groups and due to lack of transport options across the region.<br>• Catchment population has a high and growing proportion of older people, driving projected growth in demand for health services at BDH.<br>• There is an LHD-wide need to develop and maintain culturally safe infrastructure and assets (NNSWLHD Strategic Asset Management | • Service networks within the LHD will continue to be enhanced and embedded.<br>• Networking with LBH will support BDH into the future; however, is not an alternate patient pathway as LBH does not have sufficient capacity to filter high patient volumes. Additionally, the BDH catchment has a significant aged population with moderate-high levels of disadvantage, making travel to other facilities challenging with lack of transport options.<br>• Refurbishments of BDH over time have improved existing infrastructure including an expanded operating theatre, medical imaging and back-of-house capacity.<br>• The proposed redevelopment would retain and refurbish some infrastructure that is suitable and able to offer the required additional space in a flexible and contemporary way.<br>• Home-based models (e.g., HITH) and virtual care are supporting existing asset optimisation by freeing up capacity in physical clinics and services. |

| Rationale for capital requirements | Optimisation of existing assets |
|---|---|
| Plan 2023 (FY24 to FY33) pg., 38). A redevelopment of BDH would deliver updated amenity and cultural safety for the Aboriginal population, including in the proposed new ED and inclusion of Aboriginal Hospital Liaison Officer (draft Ballina CSP, pg., 39). | |
| **MDH – CT machine and refurbished space to support medical imaging department (option for phasing)** | |
| • Patients requiring CT need to be transferred to GBH as there is no CT at MDH. There are over 600 patients per year transferred from MDH to GBH for this purpose.<br>• There is no CT in the local private sector, meaning the community are required to travel to Grafton, Lismore or Ballina.<br>• Community push for improved access to CT. | • Existing CT at GBH is utilised for MDH patients; however, transfers are an ongoing cost for the LHD.<br>• The introduction of a CT at MDH will utilise space within current built capacity. |
| **GBH – short stay unit** | |
| • Required capacity as holding works prior to full GBH redevelopment completion.<br>• Will support optimal patient care through implementing the ED SSU model and will improve patient flow. | • Capacity is severely constrained in current facility. Requires investment to expand and deliver this model of care. |
| **Staff accommodation – Grafton as priority** | |
| • Challenges in the recruitment and retention of critical staff, in part due to constrained housing supply.<br>• For example, the draft Ballina CSP notes that ambulatory care vacancies are reducing the capacity of services, including to support early intervention and hospital support for hospital avoidance (pg. 66).<br>• Some clinical services are vulnerable due to inadequate workforce to meet local demand and sustainably run services.<br>• Adequate workforce levels are required to operationalise planned services at safe levels. | • Capacity already maximised across LHD owned residences.<br>• Some long-term residential leases are in place to support cost efficiencies. |
| **CDMH – ward conversion for residential aged care** | |
| • Access to residential aged care is constrained across the LHD.<br>• With an older age profile in the Casino catchment, converting unused ward space to residential aged care will support capacity. | • Residential aged care currently offered through the MPS model at four locations across the LHD.<br>• Some local private residential aged care providers have recently ceased operations which has constrained capacity across the LHD footprint. |
| **LBH – Stage 3D** | |

| Rationale for capital requirements | Optimisation of existing assets |
|---|---|
| • Final stage of LBH redevelopment works.<br>• This stage of redevelopment underpins the operational, facility support services and staff amenities required to ensure ongoing efficiency and sustainability.<br>• Works will deliver long-term options to permanently relocate services out of the flood zone. | • Current infrastructure has reached operational capacity, with some services already moved off-site, creating inefficiencies.<br>• Short-term solutions for flood affected areas have been put in place, including movement of some services to leased premises (e.g., clinical information services). |
| **Urbenville MPS – redevelopment** | |
| • Current infrastructure is aged and inadequate to support the continued delivery of efficient, high-quality and high-value healthcare services, and temporary repairs are no longer a viable or cost-effective solution.<br>• Cost of continued maintenance is high.<br>• There is a continuing need for the MPS model of health service delivery in Urbenville due to the high older population and high Aboriginal population, as well as projected growth in the older population.<br>• The high Aboriginal population has very limited access to culturally appropriate health services and aged care, as well as challenges in accessing other health services. Aboriginal community consultation would inform redevelopment to ensure spaces and services are accessible for the local Aboriginal population.<br>• Currently there is insufficient residential aged care beds to meet population need across NNSWLHD and capacity could be enhanced through this redevelopment. | • The current facility has undergone remedial and ongoing maintenance works over previous years; however, continuing these short-term fixes will not deliver longer-term efficiencies.<br>• The Urbenville community is relatively isolated (MMM5)[13], has limited access to other primary healthcare services, and is a minimum 1.5 hour drive from LBH.<br>• There is limited access to general practice and non-government health services which places the MPS as the key provider of all health services in the region. |
| **MDH – acute ward refurbishment / redevelopment** | |
| • Facility is in extremely poor condition with aged assets and infrastructure which are causing staff and patient safety concerns.<br>• The acute ward is not fit-for-purpose and has identified infection control risks which need to be mitigated. | • Repairs and maintenance works have supported ongoing service provision over prior years; however, the age and quality of the ward is not fit-for-purpose and minor remedial works are unable to improve the ward to the required level. |
| **LBH – mental health inpatient unit refurbishment** | |
| • Patient care and operational efficiency are impacted by functional issues of the building, including water ingress. This work is categorised | • There are other mental health inpatient units across the LHD. However, the unit at LBH is required to be functional to deliver safe patient |

[13] Australian Government Department of Health. (2019): modified-monash-model---fact-sheet.pdf (health.gov.au)

| Rationale for capital requirements | Optimisation of existing assets |
|---|---|
| as 'must do (immediate)' in the NNSWLHD AMP 2023 (FY24 to FY28) (pg. 29). | care, particularly as it is a role delineation level 5 and declared service. |
| **LBH – Crawford House** | |
| • The Crawford House block is aged and in poor condition. There are identified staff safety issues which require remediation. | • Crawford House is still in use despite its poor condition and identified issues.<br>• Current built capacity in other areas of the LHD (including at the new TVH) is not sufficient to house LHD staff currently located at LBH. |

### 3.1.2 Operational efficiencies considered

As work is progressed on the service change actions outlined in this Plan, a number of operational efficiencies will be explored and implemented where appropriate and feasible, including:

- Any capital development or redevelopment will consider flexible and shell spaces, as well as the ability to re-purpose or expand areas based on clinical need. This would be explored in-depth during detailed facility planning and design phases.
- Capital investment will deliver integrated and co-located services, such as the Integrated Ambulatory Care Centre (IACC) proposed as part of the future BDH redevelopment. This integrated model would create the ability to share common resources and enable operational and staffing models that support multidisciplinary team functioning, as outlined in the draft BDH CSP (pg., 66).
- The 'role of facilities' and 'vulnerable clinical services' priorities will review and consider how facilities and services are operating and there may be resultant changes in service delivery including centralised models, cessation of some services due to lack of critical mass and/or resources (e.g., workforce), and partnership approaches to care delivery.
- The implementation of a clinical stream model is anticipated to achieve operational efficiencies due to greater consistency in service models and provision across the LHD. As an example, a 23-hour surgery (or extended day only) model and increased lists per theatre session are operational efficiencies being explored in the NNSWLHD Surgical Services Plan (in development). These models are appropriate to implement across several facilities, including as outlined in the Clarence Valley CSP (pg., 58), draft BDH CSP (pg., 50-52) and Tweed Valley Service Statement 2020 (pg., 33).
- New models of care which can be safely delivered in contemporary spaces will support efficiencies, including:
  - The trial of a Mental Health Short Stay Unit (MH SSU) at TVH which will aim to improve patient flow and reduce mental health extended stays in ED (>24 hours).
  - Delivery of a Geriatric Evaluation and Management (GEM) and other models specific to older people will improve efficiencies across the service network as there will be opportunities to concentrate resources to deliver comprehensive multidisciplinary care (draft BDH CSP, pg., 41).
- The increased uptake of ambulatory, home-based and virtual care options will support operational efficiencies through delivering care in the most appropriate settings, reducing the need for patient transport and admissions into acute facilities.

### 3.1.3 Impact of recent capital development

#### 3.1.3.1 Tweed Valley Hospital

- Staff accommodation needs will be supported through eight planned on-call facilities for staff; however, this will not be sufficient for the size of the fully operational hospital.
- Increased service capacity and level of services (including some new services) to meet the demand of the growing Tweed region, as well as growth in the southern Gold Coast and Byron areas.
- A dedicated ambulatory care centre will support increased capacity, multidisciplinary care, and focus on priority populations and disease (Tweed Valley Service Statement 2020, pg., 78).
- Planned delivery of an integrated older persons model of care including GEM unit, inpatient unit, access to physical therapy gym, expanded community/ambulatory services (Tweed Valley Service Statement 2020, pg., 58-59).
- Specialist mental health inpatient unit and increased levels of ambulatory mental health and AOD consultation space (Tweed Valley Service Statement 2020, pg., 70, 73).
- Cultural safety and access for Aboriginal patients, families and carers considered in planning and design. Aboriginal workforce models have also been considered, including Aboriginal Health Liaison Officers.

#### 3.1.3.2 Grafton Base Hospital (first phase)

- New Ambulatory Care Centre is operational and supporting increased capacity and service delivery.
- The Clarence Valley CSP notes that flexible consultation and interview spaces are required to support ambulatory care growth, and technology solutions (e.g., bookings) will increase service efficiency (pg., 72).
- Cultural safety and access for Aboriginal patients, families and carers considered in planning and design.

#### 3.1.3.3 Lismore Base Hospital (stage 3C)

- Provided contemporary facilities to support ambulatory care, rehabilitation, outpatients and allied health facilities.

### 3.1.4 Summary of options considered

Table 4: Current capital and infrastructure priorities to support delivery of Priority Focus Areas - summary of options considered

| Capital / infrastructure priority | Options considered |
|---|---|
| GBH | • N/A – redevelopment in progress. |
| BDH – short-term refurb (long-term greenfield) | • A redevelopment on the current BDH site was an election commitment; however, there is currently no funding in forward budget plans.<br>• Advice has been received that the current BDH site is subject to flood risk so is not a viable redevelopment option.<br>• Based on the above, a full redevelopment on a greenfield site is a preferred long-term option.<br>• The preferred short-term option is to refurbish/redevelop areas of the facility which are not fit-for-purpose and/or require expansion to meet growing patient demand. |
| MDH – CT | • Maintain status quo, transferring patients requiring CT to GBH.<br>• Advocate for improved access to CT in the private sector within the catchment area.<br>• Options to deliver CT at Maclean include purchase of equipment and either:<br>— small-scale refurbishment to support equipment and CT service delivery.<br>— larger refurbishment within current physical capacity to deliver a broader medical imaging department at MDH (can be phased approach with phased funding). |
| GBH – SSU | • Maintain status quo. Current capacity is constrained and unable to deliver this model. |
| Staff accommodation – Grafton as priority | • See Early Options Analysis from 2023 CIP submission (appendix F).<br>• Public-private partnership models are being explored for Lismore and Tweed. |
| CDMH – ward conversion for RAC | • Maintain status quo. Unused ward space remains without a functional purpose.<br>• Advocate for increased residential aged care placements in private facilities.<br>• Expand capacity in MPS sites already delivering residential aged care. |
| LBH – Stage 3D | • See Early Options Analysis from 2023 CIP submission (appendix F). |
| Urbenville MPS redevelopment | • See Early Options Analysis from 2023 CIP submission (appendix F). |
| MDH – acute ward refurbishment | • Maintain status quo with ongoing maintenance and temporary repairs. This option will continue to have negative impacts on patient care, patient experience, staff experience and operational efficiency. Potential risks of regulatory and/or legal impacts. |
| LBH – MH inpatient unit | • Maintain status quo with ongoing maintenance and temporary repairs. This option will continue to have negative impacts on patient care, patient |

| Capital / infrastructure priority | Options considered |
|---|---|
| | experience, staff experience and operational efficiency. Potential risks of regulatory and/or legal impacts. |
| LBH – Crawford House | • See Early Options Analysis from 2023 CIP submission (included within Lismore stage 3D) (appendix F). |

## 3.2 Workforce

The tables below outline the identified workforce risks, mitigation strategies and financial implications related to the Priority Focus Areas.

Table 5: List of workforce risks, mitigation strategies and financial implications

| Workforce risks | Mitigation strategies | Financial implications |
|---|---|---|
| 1. Possible new governance structures and reporting lines.<br>2. Possible changes in role descriptions and/or responsibilities.<br>3. Current staff not in agreeance with proposed changes.<br>4. Unable to recruit required FTE, including into specialised roles (e.g., geriatrics, AOD).<br>5. Change to staff mix may lead to some staff shortages.<br>6. Ability to recruit to specialised roles that may not have previously been delivered in the LHD (e.g., radiation oncology at TVH).<br>7. Ability to fund required FTE, including to deliver new services (e.g., youth AOD).<br>8. Ongoing challenges staffing some facilities (e.g., MPSs).<br>9. Staff competence in delivering virtual care.<br>10. Reduction in FTE or movement of staff to align with population need.<br>11. Ability to increase and maintain LHD Aboriginal workforce at ≥5%.<br>12. Turnover of Aboriginal staff.<br>13. Inadequate local housing and staff accommodation to support recruitment.<br>14. Industrial body actions.<br>15. Ability to recruit and retain required FTE to deliver maintenance and support services (e.g., trades). | 1. Consultation models for staff and industrial bodies.<br>2. Costing and analysis undertaken to inform options.<br>3. Detailed planning undertaken to align service delivery to population need.<br>4. Local recruitment and marketing campaigns.<br>5. Overseas recruitment.<br>6. Increased scope of practice.<br>7. New or changed models of care and staffing models to operationalise proposed new services (e.g., GEM unit(s), perinatal AOD service).<br>8. Medical, nursing and allied health training and incentives.<br>9. Providing education and training at a local level to support entry-level positions.<br>10. Upskilling, rotation and mentoring opportunities.<br>11. Recognition of Aboriginal health qualification.<br>12. Advocate for new and/or improved traineeship and other workforce models for hard to fill areas (e.g., apprenticeships and trade services).<br>13. Advocate for exemptions to the Rural Health Workforce Incentives Scheme in areas of identified need which are not currently classified as a rural or regional location under the Scheme (e.g., the new TVH).<br>14. Improved streamlining and support for recruitment and onboarding processes. | 1. Additional FTE requirement, subject to available funding.<br>2. Financial impact offset opportunities due to changed roles and structures (e.g., Ice Inquiry funding).<br>3. Rural Health Workforce Incentives Scheme available to some role types.<br>4. Accommodation and relocation subsidies available.<br>5. Implications to be considered in detailed business plans. |

Table 6: Workforce impacts, risks, mitigation strategies and financial implications aligned to Priority Focus Areas

| Workforce impacts | Workforce risks relevant to Priority | Mitigation strategies relevant to Priority | Financial implications relevant to Priority |
|---|---|---|---|
| **Clinical streams** | | | |
| Dependent upon number of streams, there will be an FTE requirement for medical/nursing lead and support roles. | 1, 2, 3, 4, 13, 14<br>**Risk likelihood:** Moderate to high. | 1, 2, 3, 4, 5, 13, 14 | 1, 2, 3, 4, 5 |
| **Role of facilities** | | | |
| With new and upgraded facilities (e.g., TVH), there may be impacts on other facilities and the skill-mix required to deliver services across the LHD. | 3, 5, 6, 8, 13, 14, 15<br>**Risk likelihood:** High | 1, 2, 3, 4, 5, 12, 13, 14 | 1, 3, 4 |
| **Ambulatory care** | | | |
| • New models of care<br>• Provision of services through virtual care technologies.<br>• FTE uplift into priority areas.<br>• Increase in the use of Nurse Practitioner and senior allied health roles. | 1, 2, 9, 14<br>**Risk likelihood:** High | 1, 2, 4, 5, 6, 13, 14 | 1, 3, 4 |
| **Vulnerable clinical services** | | | |
| • Dependent upon outcomes of analysis, change in FTE (+/-) may be required.<br>• Service delivery models may change and there may be requirement to outsource activity. | 3, 4, 10, 13, 14<br>**Risk likelihood:** High | 1, 2, 3, 4, 5, 13, 14 | 1, 2 |
| **Empowering Aboriginal health** | | | |
| • New models of care (e.g., rheumatic heart disease and cancer care).<br>• Closing the Gap agreement.<br>• New or additional roles, e.g., Aboriginal peer support workers. | 4, 11, 12<br>**Risk likelihood:** High for some key positions. | 9, 10, 11, 13, 14 | 1, 3, 4 |
| **Care for older people** | | | |

| Workforce impacts | Workforce risks relevant to Priority | Mitigation strategies relevant to Priority | Financial implications relevant to Priority |
|---|---|---|---|
| • Uplift in FTE to deliver required services.<br>• Consideration of alternative roles, e.g., Community Geriatric CNC, Healthcare Assistant, Allied Health Assistant, Allied Health Professionals; social sector roles. | 4, 7, 8, 9, 13, 14<br>Risk likelihood: High. Growing aged population driving requirement for new and enhanced models of service delivery. | 1, 3, 4, 5, 7, 8, 10, 13, 14 | 1, 3, 4, 5 |
| **Mental health and AOD services** | | | |
| • Uplift in FTE, including peer workforce, ambulatory services.<br>• Additional FTE needed to operationalise inpatient beds at TVH. | 4, 7, 13<br>**Risk likelihood:** Moderate to high. | 1, 2, 3, 4, 5, 13, 14 | 1, 2, 3, 4, 5 |

## 3.3 Environmental sustainability and climate risk

### 3.3.1 Resource management

- Realignment of services and governance structures through implementing clinical streams may support opportunities to reduce environmental impact of service delivery, e.g., emissions related to anaesthetic products.
- Opportunities to consistently apply best practice within and across clinical streams (e.g., in relation to medicine usage).
- A review of the role of facilities will allow resource management opportunities to be realised and scaled-up where applicable.
- Opportunities to centralise some services may create efficiencies, e.g., offering some services at less sites.
- Increasing capacity in ambulatory settings and diverting demand from acute facilities will aim to reduce overall resource usage which is higher in acute facilities.
- A focus on older people and supporting this population group in the community and keeping them healthy for longer will aim to reduce overall resource usage which is higher in acute facilities.
- A review of vulnerable clinical services and subsequent planning and service delivery based on population need will have a focus on sustainable operations.
- There is a focus on partnership models of service delivery across priority areas which may deliver resource sustainability opportunities.
- Work towards 2023-24 Service Agreement KPIs (e.g., relating to reducing desflurane and nitrous oxide use, energy use avoided through energy efficient and renewable energy project implementation; waste streams).

### 3.3.2 Transport and logistics

- Increased use of virtual care to support service access across the LHD may create opportunities to reduce the use and environmental impact of transport and logistics, including emission reduction. This is applicable across all priority areas.
- Transition to electric vehicle fleet (NNSWLHD AMP 2023, pg., 24).
- Potential improvements in referral, patient pathways and transfer processes through a review of facility roles.
- Work towards 2023-24 Service Agreement KPIs (passenger vehicle fleet optimisation).

### 3.3.3 Building, design and asset management

- Focus on assets being ‘net zero ready’ (NNSWLHD AMP, pg., 25).
- Proposed capital investments, if funded, will consider environmental sustainability in design, including solar, low energy lighting, electric vehicle charging, etc.

- Work towards 2023-24 Service Agreement KPIs (e.g., energy use avoided through energy efficient and renewable energy project implementation; waste streams).
- Further exploration of building, design and asset management will occur throughout phases 2-3 of this Plan.

### 3.3.4 Supply chain and procurement

- Procurement and supply chain efficiencies may be realised through streaming clinical services, as this will support LHD-wide governance, decision-making, and leadership, as well as reducing duplication.
- Procurement and supply chain efficiencies may be realised through realignment of facility roles and what services are delivered where.
- Continuing to deliver local Leading Better Value Care initiatives and focus on high-value services may support more efficient procurement practices.

### 3.3.5 Physical climate risks

Table 7: Physical climate risks and mitigation strategies

| Key risks | Potential mitigation strategies |
|---|---|
| • Physical climate risks relating to the priority focus areas are location dependent but include flood (e.g., BDH, GBH, LBH) and bushfire (e.g., Urbenville and Bonalbo MPS) impact. Some facilities are within probable maximum flood zones, and some have been evacuated in the past due to flood or bushfires.<br>• Flood and bushfire impacts can make services inaccessible.<br>• If a service is already vulnerable (e.g., very low staffing levels), there is high risk that the service would not be able to operate in some extreme weather events. | • Undertake site-based climate risk assessment.<br>• Emergency management plans in place, including thresholds for evacuation.<br>• In the event that some services are centralised or delivered in only a number of sites (through review of facility roles or implementing clinical streams), critical service sustainability needs to be considered in plans.<br>• Work with Aboriginal communities and organisations for input into LHD plans.<br>• Clear communications within LHD and with other relevant local and emergency services, including the State Emergency Service (SES).<br>• Water tanks at relevant facilities for fire mitigation (e.g., already in place at Urbenville, conducted as part of remedial works).<br>• Expanded use of virtual care would aim to support ongoing service delivery during extreme weather events. This would require commensurate uplift in staff capability to utilise virtual care, as well as system capacity for delivery (e.g., IT systems). This would be dependent on web and tele service access.<br>• Consider service capacity optimisation where required to meet population demand and ensure sustainability.<br>• Capital and infrastructure investment required to mitigate further damage and risks to assets, such as the LBH mental health IPU (outlined in the NNSWLHD AMP 2023, pg., 29). |

### 3.3.6 Health-related climate risks

- Higher frequency and intensity of extreme weather events can contribute to hospitalisations and ED presentations. The ability to meet demand in these instances will be considered in emergency management plans.
- Vulnerable population groups are at higher risk in extreme weather conditions and events (e.g., older people in extreme heat), as well as people with existing health conditions.
- Impacts of climate change can worsen existing health conditions, including mental health.
- The Aboriginal population in the LHD are vulnerable to health-related climate risks due to the location of communities and housing and this increases risks of displacement. There is also a disproportionate burden of health conditions that may be worsened by climate events.
- There are opportunities to deliver public health/community messaging in coordination with partner services in extreme weather events.

### 3.3.7 Financial offsets

- Will be explored throughout phases 2-3 of this Plan as there are dependencies on other plans which are yet to be developed.

## 3.4 Networking and partnerships within the LHD and with external service providers

### 3.4.1 Networking within the LHD

- Opportunities to improve coordination, service efficiency and medical governance through clinical streaming.
- New service networks and referral pathways will be adopted in the LHD when:
  - new streamed service organisation is operationalised.
  - any changed facility roles are operationalised, including considering changed patient flows with the opening of the new TVH.
  - any services are changed (e.g., enhanced, reduced or ceased), including the operationalisation of targeted services such as chronic care, Aboriginal population-based programs, and mental health and AOD youth services.
- Planned increase in outpatient services and referral pathways.
- Adopt hub-and-spoke models within the LHD where specialist clinicians are unavailable locally.
- Opportunities to broaden the scope and improve medical governance of HITH services.
- Planned delivery of MPS model for residential aged care places.
- Increase aged care specialist services in the LHD.
- Increase community and outpatient provisions for specialist aged care services.
- Planned increase in outpatient clinics for mental health and AOD.

### 3.4.2 Networking with other local health service providers

- Integrated care models and service delivery approach will be embedded within the way clinical streams are developed and implemented.
- Once any changed facility roles are operationalised, there may be opportunities to consider new and/or changed networking with partner organisations.
- NNSWLHD will continue to collaborate and seek involvement with new developments that may affect networking and patient flow across the LHD footprint, e.g., the proposed new private hospital to be built opposite LBH.
- Explore integrated and coordinated care models with partners, including:
  - improved improved coordination with Healthy North Coast already in place to improve patient access to care in the right settings.
  - determining priority areas for possible co-commissioning with Healthy North Coast.
  - working with local ACCHO and AMSs to improve access to culturally safe services for the Aboriginal population.
- Based on the outputs of population-based service need analysis, explore integrated and coordinated care models with partners where relevant. This may include considering service delivery which can safely and appropriately delivered through primary care.

- Deliver the joint Mental Health, AOD and Suicide Prevention Strategy with Healthy North Coast.

### 3.4.3 Networking with other local service providers

Enhancements to integrated and coordinated care models will be explored, including through:

- Embedding integrated care approaches into clinical stream development and implementation.
- Reviewing patient pathways and referral processes and considering the impacts/opportunities for NGO partners. This will include a focus on priority population groups and those at high risk, including youth and LGBTIQ+.
- In partnership with Healthy North Coast, explore integrated approaches with RACFs, such as:
  - Nurse-led in-reach to RACFs.
  - Other treat-in-place models (including through virtual care) for RACFs to reduce transfer to hospital and/or reduce length of stay in hospital (e.g., earlier discharge with appropriate follow-up in place).

### 3.4.4 Networking with other LHDs/SNs

There is high likelihood that new networks and patient referral and pathway arrangements will be required to continue to deliver required clinical services in a sustainable way into the future. The below will be considered and further explored during phase 2 and 3 of this Plan, and discussion with relevant LHD/SNs will occur as required.

- Explore predominantly virtual hub-and-spoke models of care where, for example, the appropriate level of specialist workforce cannot be maintained, and there is a clear local need for service delivery. This may include with neighbouring MNCLHD (e.g., to combine services to obtain a critical mass), as well as considering partnerships with metro LHDs that deliver best practice models virtually (e.g., Sydney LHD and SCHN).
- Enhanced partnership and planning with MNCLHD may be considered, specifically for the lower part of the Clarence Valley and where there are opportunities to minimise transfer of vulnerable or at-risk patients further away from their homes (e.g., transfers to Coffs Harbour Health Campus rather than LBH).
- Changes to facility roles may necessitate new or changed referral and patient pathways with other LHDs.
- If a new mental health ICU is considered feasible and able to be established for the northern part of the state, this would reduce the need for clinically risky patient transfers to John Hunter, Sydney or cross-border.

Any new or changed networking arrangements will consider supporting Aboriginal people and families/carers to remain as close to home as possible and limit movement from country, culture and support.

### 3.4.5 Cross-border services or health services in other states

There is high likelihood that new networks and patient referral and pathway arrangements will be required to continue delivering highly specialised clinical services in a sustainable way into the future. NNSWLHD will review the requirements for any changed or new cross-border services with Queensland Health. This may include:

- Explore new or enhanced hub-and-spoke models of care (including virtual models) with health services in Queensland, where, for example, the appropriate level of specialist workforce cannot be maintained, and there is a clear local need for service delivery.
- Implement new and/or changed patient referral pathways after presentation and/or admission to and from cross-border services.
- Consider risks to NNSWLHD residents in accessing cross-border services, including for elderly or frail patients who face limitations in accessibility and transport.
- Explore how patient information can be shared in a timely and secure way to support optimal patient care.
- Formalise and improve patient transfer processes for cross-border services.

Any new or changed networking arrangements will consider supporting Aboriginal people and families/carers to remain as close to home as possible and limit movement from country, culture and support.

### 3.4.6 Health place/precinct considerations

- Potential opportunities for co-location and precinct approaches with service partners will be explored based upon strong partnerships and future planning of the region and its communities.
- Any future developments and redevelopments will be consistent with the NSW Government Design Guide for Health: Spaces, Places and Precincts, which includes providing culturally safe environments for Aboriginal people. Consideration will also be given to the health literacy environment including accessibility, processes and health information, to support people to understand and access the information and care they need in the right settings.
- Consideration will be given to regional and local plans, e.g., North Coast Regional Plan 2041; Richmond Valley Growth Management Strategy (draft), as well as private development (e.g., new private hospital proposed for Lismore).
- Staff accommodation options (if capital funding is identified) are considering shared buildings (e.g., with other NSW Government departments in Lismore).

### 3.4.7 Education, teaching and research

- When developing and implementing new models of care or programs, NNSWLHD research principles will be used as a guide.
- Any service changes will be informed by a range of high-quality sources and best practice. Using various data and data analytics will support defining the current state and development of monitoring and evaluation mechanisms.

- Implementation of a clinical stream model may support new and/or more consolidated opportunities or approaches to research.
- New or expanded teaching and training opportunities may arise through clinical streams as well as uplifts in service capability in the LHD, for example at the new TVH. This may include in partnership with specialist medical colleges (e.g., new geriatric and anaesthetic training positions) and for in-demand skill sets, role types and increased scope of practice workforce models (e.g., Nurse Practitioner).
- Evaluation mechanisms will be considered and built into model of care/program implementation where applicable, to ensure adequate outcome measurement and potential for scalability. For example, the trial of the MHSSU at the new TVH and Aboriginal-specific population-based and palliative and end-of-life programs.
- Enhanced reporting of Aboriginality will support evaluation of service and program implementation.
- Opportunities to consider new models of training to support development and maintenance of skills, e.g., through rotational training partnerships with other LHDs or cross-border.

## 3.5 Impact on support and enabling services or potential opportunities

Table 8 outlines potential impacts of the Priority Focus Areas on support and enabling services. Any potential impacts will be discussed with relevant entities once details are further articulated as this will enable a more informed discussion with stakeholder groups. For example, once a clinical stream model is determined for NNSWLHD, the proposed implementation approach and any potential impacts will be discussed with the relevant partner agencies.

Table 8: Possible impacts on support and enabling services

| NSW Health Pathology / other pathology provider | eHealth / other IT provider | NSW Ambulance | HealthShare NSW or other provider | Patient transport / travel |
|---|---|---|---|---|
| **Clinical streams** | | | | |
| **Potential impact:** Y<br>Possible higher concentration of pathology requirements in central locations across the LHD, dependent upon stream functions.<br>**Opportunities:**<br>Increased efficiency. | **Potential impact:** Y<br>Intended increase in use of virtual care.<br>**Opportunities:**<br>Service efficiency and access improvements through virtual health. | **Potential impact:** Maybe<br>Possible that changed service delivery models may:<br>• Reduce transfer requests.<br>• Require changes to where patients are transferred. | **Potential impact:** Maybe<br>Impact will be dependent upon determination of streams and model for NNSWLHD. | **Potential impact:** Y<br>Dependent upon streams, there may be requirement for patient movement between facilities, e.g., so patient receives care at the required level.<br>**Opportunities:**<br>Use of virtual care may reduce impact where clinically appropriate. |
| **Role of facilities** | | | | |
| **Potential impact:** Y<br>Changed facility roles will likely result in possible higher concentration of pathology requirements in central locations across the LHD, and reductions in other areas. | **Potential impact:** Y<br>Intended increase in use of virtual care.<br>**Opportunities:**<br>Service efficiency and access improvements through virtual health. | **Potential impact:** Y<br>Changed facility roles may require review of the ambulance patient allocation matrix to ensure patients are transported to the most clinically appropriate facility.<br>**Opportunities:**<br>May include renewed focus on relevant KPIs (e.g., Transfer of Care). | **Potential impact:** Y<br>Changed facility roles may have flow-on impact on HealthShare, such as potential uplift/decrease in cleaning, linen and food services at some sites.<br>**Opportunities:**<br>Potential for efficiencies through review of facility roles and patient mix. | **Potential impact:** Y<br>Dependent upon outcomes of a review of facility roles, there may be requirement for patient movement between facilities, e.g., to where a service is delivered or to peripheral sites for step-down care.<br>**Opportunities:**<br>• Use of virtual care may reduce impact |

| NSW Health Pathology / other pathology provider | eHealth / other IT provider | NSW Ambulance | HealthShare NSW or other provider | Patient transport / travel |
|---|---|---|---|---|
| | | | | where clinically appropriate.<br>• Clearly articulated facility roles will assist in patients attending or being transferred to the correct facility for the care they need. |
| **Ambulatory care** | | | | |
| **Potential impact:** Not directly. | **Potential impact:** Y<br>Intended increase in use of virtual care.<br>**Opportunities:**<br>Service efficiency and access improvements through virtual health. | **Potential impact:** N | **Potential impact:** Y<br>Reduced demand for HealthShare services if increased patient activity moved to ambulatory settings.<br>**Opportunities:**<br>Delivering more services in the community and reducing length of stay in acute facilities may reduce services such as cleaning, linen, food. | **Potential impact:** N |
| **Vulnerable clinical services** | | | | |
| **Potential impact:** Y<br>Possible higher concentrations of pathology requirements in central locations across the LHD.<br>**Opportunities:** Efficiencies could be realised through a focus on high-value care and procedures (e.g., reduced need for pathology). | **Potential impact:** Y<br>Intended increase in use of virtual care.<br>**Opportunities:**<br>Service efficiency and access improvements through virtual health. | **Potential impact:** Y<br>If a clinical specialty/sub-specialty moves to a centralised function (for example), this may require further ambulance transfer. This would also apply in the scenario that a service is no longer provided by NNSWLHD, and a patient may require | **Potential impact:** Y<br>Will be dependent upon analysis of vulnerable services. | **Potential impact:** Y<br>Dependent upon analysis of vulnerable services, movement of patients may be required.<br>**Opportunities:**<br>Use of virtual care and/or establishing new partnership models may reduce impact. |

| NSW Health Pathology / other pathology provider | eHealth / other IT provider | NSW Ambulance | HealthShare NSW or other provider | Patient transport / travel |
|---|---|---|---|---|
| | | transfer to MNC or cross-border. | | |
| **Empowering Aboriginal health** | | | | |
| **Potential impact:** Not directly. | **Potential impact:** Y<br>Intended increase in use of virtual care.<br>**Opportunities:**<br>Service efficiency and access improvements through virtual health. | **Potential impact:** Y<br>Impact related to workforce and cultural safety.<br>**Opportunities:**<br>• Partner with local Ambulance stations to improve provision of culturally safe and appropriate services.<br>• Promote Aboriginal participation in paramedic training and workforce. | **Potential impact:** N | **Potential impact:** Y<br>Impact related to workforce and cultural safety.<br>**Opportunities:**<br>Partner with local providers to improve provision of culturally safe and appropriate services. |
| **Care for older people** | | | | |
| **Potential impact:** Y<br>Focus on delivering increased levels of care outside hospital settings may alter pathology requirements. | **Potential impact:** Y<br>Intended increase in use of virtual care.<br>**Opportunities:**<br>• Service efficiency and access improvements through virtual health.<br>• Strengthening supporting infrastructure with key partners, e.g., community-based services and RACFs. | **Potential impact:** Y<br>Actions may result in reduced ambulance transfer to hospital for the older population.<br>**Opportunities:**<br>• Reduced transfer from RACF to hospital with appropriate models of care in place.<br>• Greater role in referring older people who fall to non-hospital support services when they do not require transfer to hospital. | **Potential impact:** Y<br>Any additional inpatient services that generate increases in patient days (e.g., operationalisation of GEM units) will have commensurate impact on HealthShare service delivery.<br>**Opportunities:**<br>Delivering more services in the community and reducing length of stay, may reduce services such as cleaning, linen, food. | **Potential impact:** Y<br>• There may be requirement for patient movement between facilities, e.g., to where a service is delivered or to peripheral or MPS sites for step-down, sub-acute or residential care.<br>• Increasing demand for patient transport due to growing and ageing population. |

| NSW Health Pathology / other pathology provider | eHealth / other IT provider | NSW Ambulance | HealthShare NSW or other provider | Patient transport / travel |
|---|---|---|---|---|
| | | | | **Opportunities:**<br>Providing increased levels of care in ambulatory settings may reduce impact. |
| **Mental health and AOD services** | | | | |
| **Potential impact:** Y<br>Possible increased demand due to new service model being established. | **Potential impact:** Y<br>Intended increase in use of virtual care.<br>**Opportunities:**<br>Service efficiency and access improvements through virtual health. | **Potential impact:** Y<br>(long-term) – if MHICU beds introduced in northern part of NSW.<br>**Opportunities:**<br>• Local MHICU beds could reduce long transfers of vulnerable patients to other state-wide beds (e.g., Newcastle or Sydney).<br>• Improved patient and staff safety. | **Potential impact:** Y<br>(long-term) – if MHICU beds introduced in northern part of NSW, would require commensurate uplift in HealthShare service delivery. | **Potential impact:** Y<br>Ongoing requirement for non-urgent transfer of vulnerable and complex mental health service consumers.<br>**Opportunities:**<br>• Dedicated patient transport for mental health patients (if funding identified) would improve timely and safe transfer and clinical outcomes.<br>• Use of virtual care may reduce impact where clinically appropriate. |

## 3.6 Other resource implications

Table 9 summarises other resource implications related to the delivery of the Priority Focus Areas.

Table 9: Digital and financial resource considerations

| | Clinical streams | Role of facilities | Ambulatory care | Vulnerable services | Aboriginal health | Older people | MH & AOD |
|---|---|---|---|---|---|---|---|
| **Digital infrastructure:** NNSWLHD will be guided by broader NSW Health and eHealth NSW strategy, direction and approach. Future investment in digital capacity and capability will align and integrate with NSW direction while also allowing a focus on local innovation that meets the needs of the LHD and its workforce, patients, carers and community. | | | | | | | |
| Contemporary infrastructure to support virtual care delivery, e.g., including investment in remote patient monitoring / wearable patient devices. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Effective digital capability to link facilities, services and clinicians across the LHD. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Implementation of major state-wide initiatives, e.g., the Single Digital Patient Record. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Timely ability to share and collaborate with other health services, including primary care and cross-border. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Systems in place to support development of the Aboriginal Health Dashboard and other identified business intelligence improvements. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Financial offset opportunities:** | | | | | | | |
| Enhanced coordination and consistent approaches to clinical care, along with multidisciplinary leadership, will present opportunities to reduce unwarranted clinical | ✓ | ✓ | | | | | |

| | Clinical streams | Role of facilities | Ambulatory care | Vulnerable services | Aboriginal health | Older people | MH & AOD |
|---|---|---|---|---|---|---|---|
| variation and low value care, for example, at end of life and low value surgery or procedures. | | | | | | | |
| Strengthened workforce models and reduce utilisation of higher-cost casual and contract staff. | ✓ | | | | | | |
| Potential for divestment in some service areas, e.g., through changed facility roles and possible centralisation of services. | | ✓ | | ✓ | | | |
| Potential for reinvestment in services or facilities based on demand. | | ✓ | | ✓ | | | |
| Identify and consolidate revenue generation potential across services. | ✓ | | | | | | |
| Increased partnership approaches to service delivery. | | ✓ | | | | ✓ | ✓ |
| Long-term savings potential from:<br>• Reduced demand / growth trajectory for acute facilities.<br>• Investment in early intervention and health literacy.<br>• Investment in community-based and community-led models. | | | ✓ | | ✓ | ✓ | ✓ |
| Focus on shift from volume to value through population-based planning for service delivery. | | | | ✓ | | | |

# 4 Appendices

# 4.1 Appendix A – Key demographic data

## 4.1.1 Population change and projections

### 4.1.1.1 Population change

The NNSWLHD population has grown 7.2% between 2016-2021 to a total population of 311,508 people. This rate of growth is less than NSW (7.9%) and Australia (8.6%) over the same period (see Table 10).

Population growth across NNSWLHD has been higher in the coastal LGAs of Byron (14.5%), Ballina (10.8%), Clarence Valley LGA (6.8%) and Tweed (6.6%), while the more rural LGAs of Kyogle (4.7%), Richmond Valley (3.3%) and Lismore (2.8%) have grown more slowly (see Table 10).

The highest growth Statistical Local Areas across NNSWLHD are:

- Bangalow in Byron LGA – 22.8% to 6,958 people.
- Lennox Head - Skennars Head in Ballina LGA – 19.3% to 9,236 people.
- Byron Bay in Byron LGA – 14.9% to 10,914 people.
- Kingscliff - Fingal Head in Tweed LGA – 12.6% to 14,818 people.
- Brunswick Heads - Ocean Shores in Byron LGA – 11.7% to 9,170 people.
- Mullumbimby in Byron LGA – 11.3% to 8,896 people.
- Grafton Surrounds in Clarence Valley LGA – 10.2% to 17,533 people

Table 10: NNSWLHD population change between Census 2016 and 2021

| Local Government Area | Statistical Area Level 2 | Usual Resident Population 2016 Census | Usual Resident Population 2021 Census | Change | |
|---|---|---|---|---|---|
| | | | | n | % |
| **Tweed** | | **91,371** | **97,392** | **6,021** | **6.6%** |
| | Kingscliff - Fingal Head | 13,156 | 14,818 | 1,662 | 12.6% |
| | Murwillumbah | 8,944 | 9,501 | 557 | 6.2% |
| | Murwillumbah Surrounds | 9,654 | 10,352 | 698 | 7.2% |
| | Pottsville | 13,182 | 14,086 | 904 | 6.9% |
| | Tweed Heads | 19,417 | 20,563 | 1,146 | 5.9% |
| | Banora Point | 15,635 | 16,320 | 685 | 4.4% |
| | Terranora - North Tumbulgum | 3,244 | 3,324 | 80 | 2.5% |
| | Tweed Heads South | 8,147 | 8,423 | 276 | 3.4% |
| **Byron** | | **31,556** | **36,116** | **4,560** | **14.5%** |
| | Bangalow | 5,665 | 6,958 | 1,293 | 22.8% |
| | Brunswick Heads - Ocean Shores | 8,212 | 9,170 | 958 | 11.7% |
| | Byron Bay | 9,502 | 10,914 | 1,412 | 14.9% |
| | Mullumbimby | 7,993 | 8,896 | 903 | 11.3% |
| **Ballina** | | **41,790** | **46,296** | **4,506** | **10.8%** |
| | Ballina | 17,111 | 18,629 | 1,518 | 8.9% |
| | Ballina Surrounds | 16,832 | 18,327 | 1,495 | 8.9% |
| | Lennox Head - Skennars Head | 7,741 | 9,236 | 1,495 | 19.3% |
| **Lismore** | | **43,135** | **44,334** | **1,199** | **2.8%** |
| | Goonellabah | 13,126 | 13,591 | 465 | 3.5% |
| | Lismore | 15,280 | 15,229 | -51 | -0.3% |
| | Lismore Surrounds | 15,025 | 15,786 | 761 | 5.1% |
| **Kyogle** | | **8,940** | **9,359** | **419** | **4.7%** |
| | Kyogle | 7,312 | 7,611 | 299 | 4.1% |
| **Richmond Valley** | | **22,807** | **23,565** | **758** | **3.3%** |
| | Casino | 12,227 | 12,298 | 71 | 0.6% |
| | Casino Surrounds | 6,971 | 7,381 | 410 | 5.9% |
| | Evans Head | 5,221 | 5,643 | 422 | 8.1% |
| **Clarence Valley** | | **50,671** | **54,115** | **3,444** | **6.8%** |
| | Grafton | 18,668 | 19,255 | 587 | 3.1% |
| | Grafton Surrounds | 15,311 | 16,875 | 1,564 | 10.2% |
| | Maclean - Yamba - Iluka | 16,279 | 17,533 | 1,254 | 7.7% |
| **Tenterfield LGA (Urbenville part)** | Urbenville Suburb and Locality | 321 | 331 | 10 | 3.1% |
| **NNSWLHD Total** | | **290,591** | **311,508** | **20,917** | **7.2%** |
| **NSW Total** | | **7,480,228** | **8,072,163** | **591,935** | **7.9%** |
| **Australia Total** | | **23,401,892** | **25,422,788** | **2,020,896** | **8.6%** |

#### 4.1.1.2 Population projections

The NNSWLHD population is projected to grow 5.3% between 2021-2031 to a total of 330,731 people and a further 3.6% between 2031-2041 to a total of 335,874 people. This projected growth is less than NSW (9.4% and 10.5% respectively) over the same periods (see Table 11).

Projected population growth across NNSWLHD is higher in the northern coastal LGAs of Byron (11.8% and 5.2%), Ballina (8.7% and 3.3%) and Tweed (6.6% and 2.3%). In contrast, the rural LGAs of Kyogle (-12.9% and -8.2%) and Lismore (-4.9% and -3.3%) are projected to contract (see Table 11).

The highest projected growth by Statistical Local Areas across NNSWLHD are:

- Kingscliff - Fingal Head in Tweed LGA – 24.4% between 2021-2031 to a total of 19,910 people and a further 18.5% between 2031-2041 to a total of 23,599 people.
- Bangalow in Byron LGA – 13.9% between 2021-2031 to a total of 7,424 people and a further 11.9% between 2031-2041 to a total of 8,310 people.
- Byron Bay in Byron LGA – 12.0% between 2021-2031 to a total of 12,212 people and a further 12.7% between 2031-2041 to a total of 13,759 people.
- Mullumbimby in Byron LGA – 13.1% between 2021-2031 to a total of 10,388 people and a further 11.9% between 2031-2041 to a total of 11,624 people.
- Lennox Head - Skennars Head in Ballina LGA – 11.6% between 2021- 2031 to a total of 9,725 people and a further 10.9% between 2031-2041 to a total of 10,785 people (see Table 11).

Statistical Local Areas that are contracting across NNSWLHD include:

- Kyogle in Kyogle LGA – -12.4% between 2021-2031 to a total of 6,262 people and a further -16.9% between 2031-2041 to a total of 5,206 people.
- Lismore in Lismore LGA – -6.5% between 2021-2031 to a total of 13,972 people and a further -9.1% between 2031-2041 to a total of 12,696 people.
- Lismore Surrounds in Lismore LGA – -5.0% between 2021-2031 to a total of 14,692 people and a further -8.1% between 2031-2041 to a total of 13,502 people.
- Casino Surrounds in Richmond Valley LGA – -3.2% between 2021-2031 to a total of 6,768 people and a further -6.3% between 2031-2041 to a total of 6,342 people.
- Murwillumbah Surrounds in Tweed LGA – -0.8% between 2021-2031 to a total of 9,937 people and a further -1.8% between 2031-2041 to a total of 9,763 people (see Table 11).

Table 11: NNSWLHD population projections, 2021-2041

| Local Government Area | Statistical Area Level 2 | 2021 Projection | 2026 Projection | 2031 Projection | 2036 Projection | 2041 Projection | Change 2021-2031 | | Change 2031-2041 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | n | % | n | % |
| **Tweed** | | 98,954 | 102,915 | 106,639 | 109,745 | 112,244 | **7,685** | **7.8%** | **5,605** | **5.3%** |
| | Kingscliff - Fingal Head | 16,008 | 17,907 | 19,910 | 21,816 | 23,599 | **3,902** | **24.4%** | **3,689** | **18.5%** |
| | Murwillumbah | 9,564 | 10,105 | 10,661 | 11,180 | 11,651 | **1,097** | **11.5%** | **989** | **9.3%** |
| | Murwillumbah Surrounds | 10,020 | 9,990 | 9,937 | 9,858 | 9,763 | **-83** | **-0.8%** | **-174** | **-1.8%** |
| | Pottsville | 14,535 | 15,092 | 15,582 | 16,020 | 16,417 | **1,047** | **7.2%** | **835** | **5.4%** |
| | Tweed Heads | 20,714 | 21,194 | 21,534 | 21,667 | 21,619 | **820** | **4.0%** | **85** | **0.4%** |
| | Banora Point | 16,240 | 16,487 | 16,606 | 16,577 | 16,409 | **366** | **2.3%** | **-196** | **-1.2%** |
| | Terranora - North Tumbulgum | 3,419 | 3,527 | 3,633 | 3,738 | 3,845 | **214** | **6.3%** | **212** | **5.8%** |
| | Tweed Heads South | 8,454 | 8,614 | 8,777 | 8,889 | 8,942 | **323** | **3.8%** | **165** | **1.9%** |
| **Byron** | | 35,993 | 37,920 | 40,169 | 42,387 | 44,583 | **4,176** | **11.6%** | **4,414** | **11.0%** |
| | Bangalow | 6,516 | 6,953 | 7,424 | 7,874 | 8,310 | **908** | **13.9%** | **886** | **11.9%** |
| | Brunswick Heads - Ocean Shores | 9,050 | 9,425 | 9,826 | 10,215 | 10,597 | **776** | **8.6%** | **771** | **7.8%** |
| | Byron Bay | 10,905 | 11,448 | 12,212 | 12,984 | 13,759 | **1,307** | **12.0%** | **1,547** | **12.7%** |
| | Mullumbimby | 9,186 | 9,763 | 10,388 | 11,007 | 11,624 | **1,201** | **13.1%** | **1,236** | **11.9%** |
| **Ballina** | | 45,607 | 47,722 | 49,898 | 51,864 | 53,582 | **4,291** | **9.4%** | **3,685** | **7.4%** |
| | Ballina | 18,617 | 19,747 | 20,926 | 21,936 | 22,728 | **2,308** | **12.4%** | **1,802** | **8.6%** |
| | Ballina Surrounds | 18,097 | 18,603 | 19,078 | 19,511 | 19,914 | **980** | **5.4%** | **836** | **4.4%** |
| | Lennox Head - Skennars Head | 8,714 | 9,198 | 9,725 | 10,254 | 10,785 | **1,011** | **11.6%** | **1,060** | **10.9%** |
| **Lismore** | | 43,420 | 42,963 | 42,022 | 40,845 | 39,500 | **-1,398** | **-3.2%** | **-2,521** | **-6.0%** |
| | Goonellabah | 13,471 | 13,700 | 13,762 | 13,738 | 13,642 | **291** | **2.2%** | **-120** | **-0.9%** |
| | Lismore | 14,941 | 14,538 | 13,972 | 13,351 | 12,696 | **-968** | **-6.5%** | **-1,276** | **-9.1%** |
| | Lismore Surrounds | 15,459 | 15,156 | 14,692 | 14,131 | 13,502 | **-767** | **-5.0%** | **-1,190** | **-8.1%** |
| **Kyogle** | | 8,681 | 8,253 | 7,746 | 7,188 | 6,596 | **-935** | **-10.8%** | **-1,150** | **-14.8%** |
| | Kyogle | 7,147 | 6,735 | 6,262 | 5,747 | 5,206 | **-885** | **-12.4%** | **-1,056** | **-16.9%** |
| **Richmond Valley** | | 23,548 | 24,067 | 24,466 | 24,777 | 25,015 | **918** | **3.9%** | **549** | **2.2%** |
| | Casino | 12,594 | 13,006 | 13,334 | 13,610 | 13,848 | **741** | **5.9%** | **514** | **3.9%** |
| | Casino Surrounds | 6,992 | 6,921 | 6,768 | 6,569 | 6,342 | **-225** | **-3.2%** | **-426** | **-6.3%** |
| | Evans Head | 5,560 | 5,730 | 5,932 | 6,135 | 6,324 | **372** | **6.7%** | **392** | **6.6%** |
| **Clarence Valley** | | 51,846 | 52,561 | 53,323 | 53,925 | 54,352 | **1,478** | **2.8%** | **1,029** | **1.9%** |
| | Grafton | 19,054 | 19,377 | 19,708 | 20,018 | 20,286 | **653** | **3.4%** | **578** | **2.9%** |
| | Grafton Surrounds | 15,645 | 15,708 | 15,694 | 15,565 | 15,343 | **49** | **0.3%** | **-351** | **-2.2%** |
| | Maclean - Yamba - Iluka | 16,785 | 17,121 | 17,571 | 17,996 | 18,382 | **786** | **4.7%** | **810** | **4.6%** |
| **Tenterfield LGA (Urbenville part)** | Urbenville Suburb and Locality | Data unavailable | | | | | | | | |
| **NNSWLHD Total** | | **308,049** | **316,400** | **324,263** | **330,731** | **335,874** | **16,214** | **5.3%** | **11,611** | **3.6%** |
| **NSW Total** | | **8,166,757** | **8,462,770** | **8,933,640** | **9,404,886** | **9,872,934** | **766,882** | **9.4%** | **939,294** | **10.5%** |

## 4.1.2 Population ageing

Young children and older people are generally higher users of health services. In 2021, NNSWLHD had:

- A smaller proportion of children aged 0-14 years (14.2%) compared to NSW (18.2%) and Australia (18.2%).
- Higher proportions of people aged 65-84 years (21.7%) and 85+ years (3.2%) compared to NSW (15.4% and 2.3%) and Australia (15.1% and 2.1%) (see Table 12).

Statistical Local Areas with the highest proportions of children across NNSWLHD include:

- Terranora - North Tumbulgum in Tweed LGA – 691 children aged 0-14 years (20.9%).
- Pottsville in Tweed LGA – 2,877 children aged 0-14 years (20.4%).
- Lennox Head - Skennars Head in Ballina LGA – 1,828 children aged 0-14 years (19.8%).
- Casino in Richmond Valley LGA – 2,391 children aged 0-14 years (19.5%) (see Table 12).

Statistical Local Areas with the highest proportions of older people across NNSWLHD include:

- Maclean - Yamba - Iluka in Clarence Valley LGA – 5,309 people aged 65-84 years (30.3%) and 717 people aged 85+ years (4.1%).
- Tweed Heads South in Tweed LGA – 2,506 people aged 65-84 years (29.7%) and 595 people aged 85+ years (7.1%).
- Urbenville Suburb and Locality in Tenterfield LGA – 98 people aged 65-84 years (29.6%) and 14 people aged 85+ years (4.2%).

- Ballina in Ballina LGA – 5,276 people aged 65-84 years (28.3%) and 1,188 people aged 85+ years (6.4%).
- Tweed Heads in Tweed LGA – 5,271 people aged 65-84 years (25.6%) and 960 people aged 85+ years (4.7%) (see Table 12).

Table 12: NNSWLHD population age structure, 2021

| Local Government Area | Statistical Area Level 2 | Age groups | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 0-14 years | | 15-64 years | | 65-84 years | | 85+ years | |
| | | n | Proportion | n | Proportion | n | Proportion | n | Proportion |
| **Tweed** | | 16,084 | 16.5% | 55,376 | 56.9% | 22,082 | 22.7% | 3,844 | 3.9% |
| | Kingscliff - Fingal Head | 2,700 | 18.2% | 8,566 | 57.8% | 3,141 | 21.2% | 410 | 2.8% |
| | Murwillumbah | 1,709 | 18.0% | 5,421 | 57.0% | 1,940 | 20.4% | 442 | 4.6% |
| | Murwillumbah Surrounds | 1,694 | 16.4% | 6,427 | 62.1% | 2,079 | 20.1% | 150 | 1.4% |
| | Pottsville | 2,877 | 20.4% | 8,254 | 58.6% | 2,599 | 18.5% | 354 | 2.5% |
| | Tweed Heads | 2,756 | 13.4% | 11,586 | 56.3% | 5,271 | 25.6% | 960 | 4.7% |
| | Banora Point | 2,571 | 15.7% | 8,883 | 54.4% | 4,024 | 24.6% | 866 | 5.3% |
| | Terranora - North Tumbulgum | 691 | 20.9% | 2,016 | 60.9% | 547 | 16.5% | 54 | 1.6% |
| | Tweed Heads South | 1,086 | 12.9% | 4,238 | 50.3% | 2,506 | 29.7% | 595 | 7.1% |
| **Byron** | | 5,817 | 16.1% | 23,594 | 65.3% | 6,115 | 16.9% | 588 | 1.6% |
| | Bangalow | 1,309 | 18.8% | 4,456 | 64.0% | 1,088 | 15.6% | 112 | 1.6% |
| | Brunswick Heads - Ocean Shores | 1,483 | 16.2% | 5,921 | 64.6% | 1,614 | 17.6% | 143 | 1.6% |
| | Byron Bay | 1,493 | 13.7% | 7,552 | 69.2% | 1,706 | 15.6% | 170 | 1.6% |
| | Mullumbimby | 1,505 | 16.9% | 5,559 | 62.5% | 1,680 | 18.9% | 154 | 1.7% |
| **Ballina** | | 7,539 | 16.3% | 26,229 | 56.7% | 10,690 | 23.1% | 1,834 | 4.0% |
| | Ballina | 2,467 | 13.2% | 9,691 | 52.0% | 5,276 | 28.3% | 1,188 | 6.4% |
| | Ballina Surrounds | 3,231 | 17.6% | 10,751 | 58.7% | 3,816 | 20.8% | 532 | 2.9% |
| | Lennox Head - Skennars Head | 1,828 | 19.8% | 5,725 | 62.0% | 1,563 | 16.9% | 118 | 1.3% |
| **Lismore** | | 7,580 | 17.1% | 27,511 | 62.1% | 8,157 | 18.4% | 1,081 | 2.4% |
| | Goonellabah | 2,487 | 18.3% | 8,061 | 59.3% | 2,588 | 19.0% | 464 | 3.4% |
| | Lismore | 2,474 | 16.3% | 9,804 | 64.4% | 2,542 | 16.7% | 395 | 2.6% |
| | Lismore Surrounds | 2,672 | 16.9% | 9,820 | 62.2% | 3,082 | 19.5% | 222 | 1.4% |
| **Kyogle** | | 1,485 | 15.9% | 5,382 | 57.5% | 2,260 | 24.2% | 228 | 2.4% |
| | Kyogle | 1,248 | 16.4% | 4,333 | 56.9% | 1,826 | 24.0% | 211 | 2.8% |
| **Richmond Valley** | | 4,310 | 18.3% | 13,337 | 56.6% | 5,156 | 21.9% | 765 | 3.2% |
| | Casino | 2,391 | 19.5% | 6,764 | 55.1% | 2,676 | 21.8% | 456 | 3.7% |
| | Casino Surrounds | 1,283 | 17.4% | 4,412 | 59.8% | 1,533 | 20.8% | 145 | 2.0% |
| | Evans Head | 885 | 15.7% | 3,205 | 56.9% | 1,371 | 24.3% | 174 | 3.1% |
| **Clarence Valley** | | 8,651 | 16.0% | 30,640 | 56.6% | 13,072 | 24.2% | 1,757 | 3.2% |
| | Grafton | 3,630 | 18.9% | 10,900 | 56.6% | 3,953 | 20.5% | 772 | 4.0% |
| | Grafton Surrounds | 2,471 | 14.6% | 10,431 | 61.8% | 3,720 | 22.0% | 261 | 1.5% |
| | Maclean - Yamba - Iluka | 2,471 | 14.1% | 9,037 | 51.5% | 5,309 | 30.3% | 717 | 4.1% |
| **Tenterfield LGA (Urbenville part)** | Urbenville Suburb and Locality | 47 | 14.2% | 172 | 52.0% | 98 | 29.6% | 14 | 4.2% |
| **NNSWLHD Total** | | 51,513 | 16.5% | 182,241 | 58.5% | 67,630 | 21.7% | 10,111 | 3.2% |
| **NSW Total** | | 1,470,001 | 18.2% | 5,177,999 | 64.1% | 1,240,246 | 15.4% | 183,895 | 2.3% |
| **Australia Total** | | 4,638,006 | 18.2% | 16,406,692 | 64.5% | 3,835,746 | 15.1% | 542,342 | 2.1% |

Population projections indicate that in NNSWLHD:

- 0-14 years population group will decrease 5.4% from 52,961 to 50,098 children between 2021-2041
- 15-64 years population group will increase 0.7% from 178,460 to 179,657 people between 2021-2041
- 65-84 years population group will increase 27.5% from 66,568 to 84,881 people between 2021-2041
- 85+ years population group will increase 111.1% from 10,061 to 21,238 people between 2021-2041 (see Figure 1 and Table 13).

Population projections indicate that the Local Government Areas[14] across NNSWLHD with the highest proportions of older people in 2041 will include:

- Kyogle LGA – 1,933 people aged 65-84 years (29.3%) and 493 people aged 85+ years (7.5%).

[14] Data unavailable by Statistical Area Level 2

- Tweed LGA – 31,412 people aged 65-84 years (28.0%) and 8,193 people aged 85+ years (7.3%).
- Clarence Valley LGA – 14,588 people aged 65-84 years (26.8%) and 3,562 people aged 85+ years (6.6%).
- Ballina LGA – 14,089 people aged 65-84 years (26.3%) and 3,001 people aged 85+ years (5.8%) (see Table 13).

Figure 1: NNSWLHD population projections by age, 2021 to 2041

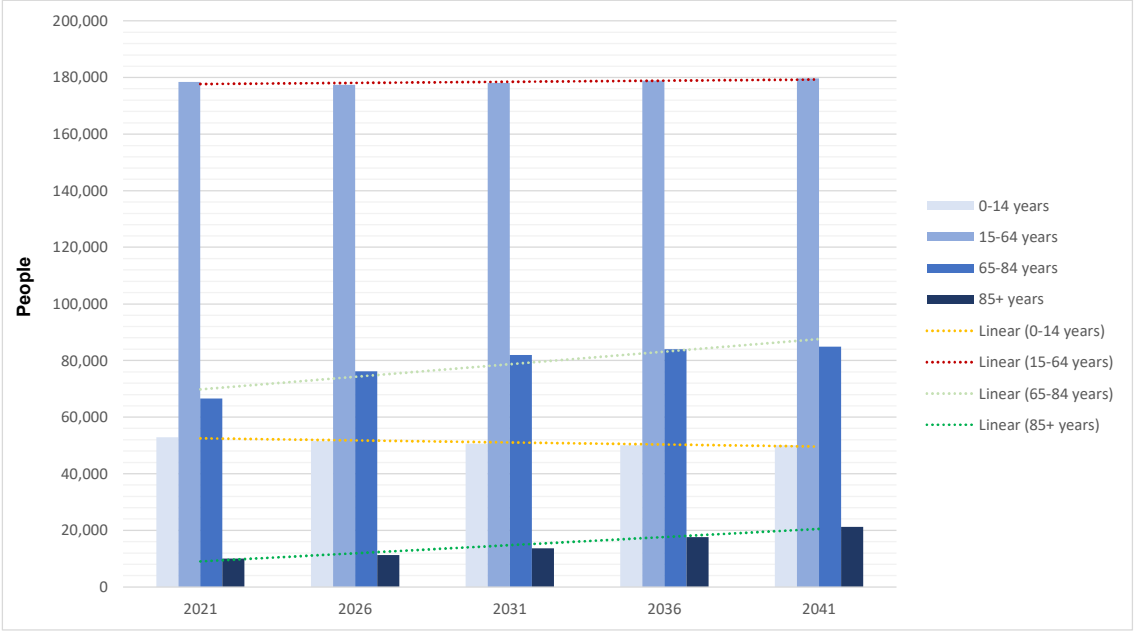

Table 13: NNSWLHD population projections by LGA and age, 2021 to 2041

| Local Government Area | Year | Age groups | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 0-14 years | | 15-64 years | | 65-84 years | | 85+ years | |
| | | n | Proportion | n | Proportion | n | Proportion | n | Proportion |
| **Tweed** | 2021 | 16,955 | 17.1% | 56,041 | 17.1% | 22,179 | 22.4% | 3,779 | 3.8% |
| | 2026 | 16,338 | 15.9% | 55,895 | 15.9% | 26,411 | 25.7% | 4,270 | 4.1% |
| | 2031 | 15,869 | 14.9% | 56,356 | 14.9% | 29,188 | 27.4% | 5,226 | 4.9% |
| | 2036 | 15,737 | 14.3% | 56,609 | 14.3% | 30,630 | 27.9% | 6,769 | 6.2% |
| | 2041 | 15,758 | 14.0% | 56,882 | 14.0% | 31,412 | 28.0% | 8,193 | 7.3% |
| **Byron** | 2021 | 6,179 | 17.2% | 22,825 | 17.2% | 6,414 | 17.8% | 575 | 1.6% |
| | 2026 | 6,348 | 16.7% | 23,573 | 16.7% | 7,350 | 19.4% | 649 | 1.7% |
| | 2031 | 6,563 | 16.3% | 24,842 | 16.3% | 7,896 | 19.7% | 869 | 2.2% |
| | 2036 | 6,797 | 16.0% | 26,183 | 16.0% | 8,185 | 19.3% | 1,221 | 2.9% |
| | 2041 | 7,099 | 15.9% | 27,438 | 15.9% | 8,484 | 19.0% | 1,563 | 3.5% |
| **Ballina** | 2021 | 7,651 | 16.8% | 25,910 | 16.8% | 10,253 | 22.5% | 1,793 | 3.9% |
| | 2026 | 7,463 | 15.6% | 26,549 | 15.6% | 11,750 | 24.6% | 1,960 | 4.1% |
| | 2031 | 7,391 | 14.8% | 27,203 | 14.8% | 12,974 | 26.0% | 2,329 | 4.7% |
| | 2036 | 7,428 | 14.3% | 27,812 | 14.3% | 13,623 | 26.3% | 3,001 | 5.8% |
| | 2041 | 7,518 | 14.0% | 28,317 | 14.0% | 14,089 | 26.3% | 3,659 | 6.8% |
| **Lismore** | 2021 | 7,613 | 17.5% | 26,772 | 17.5% | 7,927 | 18.3% | 1,108 | 2.6% |
| | 2026 | 7,073 | 16.5% | 25,715 | 16.5% | 8,895 | 20.7% | 1,279 | 3.0% |
| | 2031 | 6,657 | 15.8% | 24,655 | 15.8% | 9,203 | 21.9% | 1,506 | 3.6% |
| | 2036 | 6,345 | 15.5% | 23,596 | 15.5% | 8,978 | 22.0% | 1,925 | 4.7% |
| | 2041 | 6,063 | 15.3% | 22,569 | 15.3% | 8,582 | 21.7% | 2,287 | 5.8% |
| **Kyogle** | 2021 | 1,409 | 16.2% | 4,892 | 16.2% | 2,125 | 24.5% | 255 | 2.9% |
| | 2026 | 1,260 | 15.3% | 4,372 | 15.3% | 2,341 | 28.4% | 280 | 3.4% |
| | 2031 | 1,173 | 15.1% | 3,878 | 15.1% | 2,361 | 30.5% | 335 | 4.3% |
| | 2036 | 1,062 | 14.8% | 3,528 | 14.8% | 2,167 | 30.2% | 430 | 6.0% |
| | 2041 | 956 | 14.5% | 3,215 | 14.5% | 1,933 | 29.3% | 493 | 7.5% |
| **Richmond Valley** | 2021 | 4,443 | 18.9% | 13,314 | 18.9% | 5,024 | 21.3% | 766 | 3.3% |
| | 2026 | 4,530 | 18.8% | 13,215 | 18.8% | 5,476 | 22.8% | 846 | 3.5% |
| | 2031 | 4,497 | 18.4% | 13,199 | 18.4% | 5,756 | 23.5% | 1,015 | 4.1% |
| | 2036 | 4,456 | 18.0% | 13,275 | 18.0% | 5,783 | 23.3% | 1,263 | 5.1% |
| | 2041 | 4,434 | 17.7% | 13,306 | 17.7% | 5,794 | 23.2% | 1,482 | 5.9% |
| **Clarence Valley** | 2021 | 8,710 | 16.8% | 28,705 | 16.8% | 12,646 | 24.4% | 1,785 | 3.4% |
| | 2026 | 8,500 | 16.2% | 28,149 | 16.2% | 13,965 | 26.6% | 1,947 | 3.7% |
| | 2031 | 8,410 | 15.8% | 27,905 | 15.8% | 14,607 | 27.4% | 2,401 | 4.5% |
| | 2036 | 8,310 | 15.4% | 27,951 | 15.4% | 14,623 | 27.1% | 3,041 | 5.6% |
| | 2041 | 8,271 | 15.2% | 27,931 | 15.2% | 14,588 | 26.8% | 3,562 | 6.6% |
| **Tenterfield LGA (Urbenville part)** | Not available | | | | | | | | |
| **NNSWLHD Total** | 2021 | 52,961 | 17.2% | 178,460 | 17.2% | 66,568 | 21.6% | 10,061 | 3.3% |
| | 2026 | 51,514 | 16.3% | 177,467 | 16.3% | 76,188 | 24.1% | 11,231 | 3.5% |
| | 2031 | 50,560 | 15.6% | 178,038 | 15.6% | 81,984 | 25.3% | 13,681 | 4.2% |
| | 2036 | 50,135 | 15.2% | 178,954 | 15.2% | 83,991 | 25.4% | 17,651 | 5.3% |
| | 2041 | 50,098 | 14.9% | 179,657 | 14.9% | 84,881 | 25.3% | 21,238 | 6.3% |
| **NSW Total** | 2021 | 1,500,637 | 18.4% | 5,259,202 | 18.4% | 1,222,585 | 15.0% | 184,333 | 2.3% |
| | 2026 | 1,485,868 | 17.6% | 5,350,779 | 17.6% | 1,407,824 | 16.6% | 218,300 | 2.6% |
| | 2031 | 1,491,383 | 16.7% | 5,607,248 | 16.7% | 1,558,666 | 17.4% | 276,342 | 3.1% |
| | 2036 | 1,534,214 | 16.3% | 5,850,828 | 16.3% | 1,659,168 | 17.6% | 360,676 | 3.8% |
| | 2041 | 1,592,077 | 16.1% | 6,094,498 | 16.1% | 1,751,876 | 17.7% | 434,483 | 4.4% |

### 4.1.3 Population disadvantage

Socioeconomically disadvantaged communities tend to have low incomes, low education attainment, high unemployment and unskilled occupations. Generally, socioeconomic disadvantaged people are at greater risk of poor health and have higher rates of illness and disability. This is caused by a greater prevalence of:

- Risk factors – including obesity, lack of physical activity, uncontrolled high blood pressure and smoking.
- Chronic disease – including chronic obstructive pulmonary disease, diabetes, chronic kidney disease and coronary heart disease.

The most disadvantaged communities in NNSWLHD are in the lowest socioeconomic group (Deciles 1 and 2). They include:

- Urbenville Suburb and Locality – 855.
- Casino Statistical Area Level 2 – 891.
- Grafton Statistical Area Level 2 – 907.
- Lismore Statistical Area Level 2 – 916.
- Tweed Heads South Statistical Area Level 2 – 917.
- Kyogle Statistical Area Level 2 – 930.
- Murwillumbah Statistical Area Level 2 – 934.
- Casino Surrounds Statistical Area Level 2 – 943 (see Table 14).

NNSWLHD does not have any communities in the highest socioeconomic group (Deciles 9 and 10) (see Table 14).

Table 14: NNSWLHD index or relative socioeconomic disadvantage score, 2021

| Local Government Area | Statistical Area Level 2 | 2021 Score | Rank in NSW | | |
|---|---|---|---|---|---|
| | | | Rank | Decile | Percentile |
| **Tweed** | | 989 | 78 | 7 | 61 |
| | Kingscliff - Fingal Head | 1,029 | 382 | 7 | 61 |
| | Murwillumbah | 934 | 106 | 2 | 17 |
| | Murwillumbah Surrounds | 996 | 282 | 5 | 45 |
| | Pottsville | 1,018 | 350 | 6 | 56 |
| | Tweed Heads | 973 | 200 | 4 | 32 |
| | Banora Point | 995 | 278 | 5 | 45 |
| | Terranora - North Tumbulgum | 1,062 | 482 | 8 | 77 |
| | Tweed Heads South | 917 | 75 | 2 | 12 |
| **Byron** | | 1,021 | 100 | 8 | 77 |
| | Bangalow | 1,065 | 490 | 8 | 79 |
| | Brunswick Heads - Ocean Shores | 1,004 | 304 | 5 | 49 |
| | Byron Bay | 1,029 | 380 | 7 | 61 |
| | Mullumbimby | 993 | 272 | 5 | 44 |
| **Ballina** | | 1,015 | 98 | 8 | 76 |
| | Ballina | 975 | 204 | 4 | 33 |
| | Ballina Surrounds | 1,028 | 378 | 7 | 61 |
| | Lennox Head - Skennars Head | 1,071 | 500 | 8 | 80 |
| **Lismore** | | 966 | 46 | 4 | 36 |
| | Goonellabah | 969 | 188 | 3 | 30 |
| | Lismore | 916 | 74 | 2 | 12 |
| | Lismore Surrounds | 1,012 | 335 | 6 | 54 |
| **Kyogle** | | 921 | 13 | 2 | 11 |
| | Kyogle | 930 | 98 | 2 | 16 |
| **Richmond Valley** | | 924 | 14 | 2 | 11 |
| | Casino | 891 | 53 | 1 | 9 |
| | Casino Surrounds | 943 | 121 | 2 | 20 |
| | Evans Head | 955 | 148 | 3 | 24 |
| **Clarence Valley** | | 940 | 26 | 3 | 21 |
| | Grafton | 907 | 66 | 2 | 11 |
| | Grafton Surrounds | 951 | 139 | 3 | 23 |
| | Maclean - Yamba - Iluka | 967 | 183 | 3 | 30 |
| | | | | | |
| **Tenterfield LGA (Urbenville part)** | Urbenville Suburb and Locality | 855 | 125 | 1 | 3 |

## 4.2 Appendix B – Membership of the Clinical Planning and Clinician Engagement Committee

- Senior nursing representative
- Senior midwifery representative
- Senior medical representative
- Junior medical officer representative
- Mental health clinician
- Smaller hospitals representative
- Oral health representative
- Aboriginal or Torres Strait Islander representative
- Support services representative
- Northern NSW LHD Board representatives
- Community representative
- Healthy North Coast PHN representative
- Chief Executive
- Director, Clinical Operations
- Director, Integrated Care and Allied Health
- Director, Corporate Services
- Director, Clinical Governance
- Director, Mental Health, Alcohol and Other Drugs
- General Manager, Community Health
- LHD Executive Director Medical Services
- Associate Director, Planning
- General Manager representative
- Executive Officer/Director of Nursing representative

## 4.3 Appendix C – Consultation list

- All NNSWLHD staff invited to feedback
- Engagement Collaboration Group, NNSWLHD
- Senior Managers Forum, NNSWLHD
- Integrated Care Collaborative Group, NNSWLHD
- Executive Leadership Team, NNSWLHD
- Clinical Planning and Clinician Engagement Committee, NNSWLHD
- Community and Partnerships Advisory Council, NNSWLHD
- >80 Medical, nursing and allied health clinicians, NNSWLHD
- Service and program managers, NNSWLHD
- Facility executive and management, NNSWLHD
- Medical Staff Council Chairs, Lismore, Tweed and Grafton, NNSWLHD
- Manager, Community and Allied Health, NNSWLHD
- Cancer Services Manager, NNSWLHD
- Virtual Care Manager, NNSWLHD
- Health Promotion Team, NNSWLHD
- Aboriginal Health Team, NNSWLHD
- Integrated Care Team, NNSWLHD
- Planning Unit, NNSWLHD
- Priority Populations Strategy Officers, NNSWLHD
- Workforce Manager, NNSWLHD
- HR Manager, NNSWLHD
- WH&S Program Coordinator, NNSWLHD
- Patient Flow Manager, NNSWLHD
- Disaster Manager, NNSWLHD
- Safety and Quality Coordinators, NNSWLHD
- Infection prevention and control coordinator, NNSWLHD
- Director and Manager of Research, NNSWLHD
- Director, Public Health, NNSWLHD and MNCLHD
- Director, BreastScreen, NNSWLHD
- Manager, Capital, Assets and Resources, NNSWLHD
- Manager, Environmentally Sustainable Healthcare, NNSWLHD
- Chief Information Officer, NNSWLHD
- Chief Clinical Information Officer, NNSWLHD
- Data Analysts, NNSWLHD
- Procurement Manager, NNSWLHD

- Administration and support staff, NNSWLHD
- Mid North Coast LHD
- Centre for Aboriginal Health, NSW Ministry of Health
- Healthy North Coast PHN
- Bulgarr Ngaru Aboriginal Medical Service
- Rekindling the Spirit Aboriginal Health Service
- Bullinah Aboriginal Health Service
- NSW Nurses and Midwives Association
- Australian Salaried Medical Officers' Federation
- Health Services Union

## 4.4 Appendix D – Strategic alignment – Future Health

Figure 2: Future Health 2022-2032: Strategic Framework

| Strategic outcomes | | Key objectives |
|---|---|---|
|  | **Patients and carers have positive experiences and outcomes that matter:** People have more control over their own health, enabling them to make decisions about their care that will achieve the outcomes that matter most to them. | 1.1 **Partner with patients and communities** to make decisions about their own care<br>1.2 **Bring kindness and compassion** into the delivery of personalised and culturally safe care<br>1.3 **Drive greater health literacy** and access to information<br>1.4 **Partner with consumers** in co-design and implementation of models of care |
|  | **Safe care is delivered across all settings:** Safe, high quality reliable care is delivered by us and our partners in a sustainable and personalised way, within our hospitals, in communities, at home and virtually. | 2.1 **Deliver safe, high quality reliable care** for patients in hospital and other settings<br>2.2 **Deliver more services** in the home, community and virtual settings<br>2.3 **Connect with partners** to deliver integrated care services<br>2.4 **Strengthen equitable outcomes and access** for rural, regional and priority populations<br>2.5 **Align infrastructure and service planning** around the future care needs |
|  | **People are healthy and well:** Investment is made in keeping people healthy to prevent ill health and tackle health inequality in our communities. | 3.1 **Prevent, prepare for, respond to and recover** from pandemic and other threats to population health<br>3.2 **Get the best start in life** from conception through to age five<br>3.3 **Make progress towards zero suicides** recognising the devastating impact on society<br>3.4 **Support healthy ageing** ensuring people can live more years in full health and independently at home<br>3.5 **Close the gap** by prioritising care and programs for Aboriginal people<br>3.6 **Support mental health and wellbeing** for our whole community<br>3.7 **Partner to address the social determinants of ill health** in our communities |
|  | **Our staff are engaged and well supported:** Staff are supported to deliver safe, reliable person-centred care driving the best outcomes and experiences. | 4.1 **Build positive work environments** that bring out the best in everyone<br>4.2 **Strengthen diversity** in our workforce and decision-making<br>4.3 **Empower staff to work to their full potential** around the future care needs<br>4.4 **Equip our people with the skills and capabilities** to be an agile, responsive workforce<br>4.5 **Attract and retain skilled people** who put patients first<br>4.6 **Unlock the ingenuity of our staff** to build work practices for the future |
|  | **Research and innovation, and digital advances inform service delivery:** Clinical service delivery continues to transform through health and medical research, digital technologies, and data analytics. | 5.1 **Advance and translate research and innovation** with institutions, industry partners and patients<br>5.2 **Ensure health data and information** is high quality, integrated, accessible and utilised<br>5.3 **Enable targeted evidence-based healthcare** through precision medicine<br>5.4 **Accelerate digital investments** in systems, infrastructure, security and intelligence |
|  | **The health system is managed sustainably:** The health system is managed with an outcomes-focused lens to deliver a financially and environmentally sustainable future. | 6.1 **Drive value based healthcare** that prioritises outcomes and collaboration<br>6.2 **Commit to an environmentally sustainable** footprint for future healthcare<br>6.3 **Adapt performance measurement and funding models** to targeted outcomes<br>6.4 **Align our governance and leaders** to support the system and deliver the outcomes of Future Health |

Table 15: Priority Focus Area - Strategic alignment to Future Health

| | Clinical streams | Role of facilities | Ambulatory care | Vulnerable services | Aboriginal health | Older people | MH & AOD |
|---|---|---|---|---|---|---|---|
| **Strategic Outcome 1: Patients and carers have positive experiences and outcomes that matter** | | | | | | | |
| 1.1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 1.2 | | | ✓ | | ✓ | ✓ | ✓ |
| 1.3 | | | | | ✓ | ✓ | ✓ |
| 1.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Strategic Outcome 2: Safe care is delivered across all settings** | | | | | | | |
| 2.1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2.2 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2.3 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2.5 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Strategic Outcome 3: People are healthy and well** | | | | | | | |
| 3.1 | ✓ | ✓ | ✓ | | | ✓ | |
| 3.2 | ✓ | | ✓ | | ✓ | | |
| 3.3 | ✓ | | | | ✓ | | ✓ |
| 3.4 | ✓ | | | | ✓ | ✓ | |
| 3.5 | ✓ | | ✓ | | ✓ | ✓ | |
| 3.6 | | | | | ✓ | | ✓ |
| 3.7 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Strategic Outcome 4: Our staff are engaged and well supported** | | | | | | | |
| 4.1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.2 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.3 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.5 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.6 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Strategic Outcome 5: Research and innovation, and digital advances inform service delivery** | | | | | | | |

| | Clinical streams | Role of facilities | Ambulatory care | Vulnerable services | Aboriginal health | Older people | MH & AOD |
|---|---|---|---|---|---|---|---|
| 5.1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 5.2 | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| 5.3 | | | ✓ | | | | |
| 5.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Strategic Outcome 6: The health system is managed sustainably** | | | | | | | |
| 6.1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6.2 | | ✓ | ✓ | | | | |
| 6.3 | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

## 4.5 Appendix E – Strategic alignment – Regional Health Plan

Figure 3: Regional Health Plan 2022-2032: Strategic Framework

| Priorities | Strategic objectives |
|---|---|
| **1. Strengthen the regional health workforce:** Build our regional workforce; provide career pathways for people to train and stay in the regions; attract and retain healthcare staff; address culture and psychological safety, physical safety and racism in the workplace. | 1.1 **Invest in and promote rural generalism** for allied health professionals, nurses and doctors<br>1.2 **Prioritise the attraction and retention** of healthcare professionals and non-clinical staff in regional NSW<br>1.3 **Tailor and support career pathways for Aboriginal health staff** with a focus on recruitment and retention<br>1.4 **Expand training and upskilling opportunities, including across borders** to build a pipeline of regionally based workers<br>1.5 **Accelerate changes to scope of practice whilst maintaining quality and safety,** encouraging innovative workforce models and recognition of staff experience and skills<br>1.6 **Nurture culture, psychological and physical safety** in all NSW Health workplaces and build positive work environments that allow staff to thrive |
| **2. Enable better access to safe, high quality and timely health services:** Improve transport and assistance schemes; deliver appropriate services in the community; continue to embed virtual care as an option to complement face-to-face care and to provide multidisciplinary support to clinicians in regional settings. | 2.1 **Improve local transport solutions and travel assistance schemes,** and address their affordability, to strengthen equitable access to care<br>2.2 **Deliver appropriate services in the community** that provide more sustainable solutions for access to healthcare closer to home<br>2.3 **Leverage virtual care** to improve access, whilst ensuring cultural and digital barriers are addressed<br>2.4 **Enable seamless cross-border care and streamline pathways to specialist care** ensuring access to the best patient care regardless of postcode<br>2.5 **Drive and support improved clinical care, timely access and safety and quality outcomes** for patients in hospitals and other settings<br>2.6 **Align infrastructure and sustainable service planning** around the needs of staff and communities and to enable virtual care |
| **3. Keep people healthy and well through prevention, early intervention and education:** Prevent some of the most significant causes of poor health by working across government, community, and other organisations to tackle the social determinants of health; prepare and respond to threats to population health. | 3.1 **Address the social determinants of health** in our communities by partnering across government, business and community<br>3.2 **Invest in mental health and make progress towards zero suicides**<br>3.3 **Invest in maternity care and early childhood** intervention and healthcare to give children the best start in life<br>3.4 **Invest in wellness, prevention and early detection**<br>3.5 **Prevent, prepare for, respond to, and recover from pandemics** and other threats to population health |
| **4. Keep communities informed, build engagement, seek feedback:** Provide more information to communities about what health services are available and how to access them; empower the community to be involved in how health services are planned and delivered; increase responsiveness to patient experiences. | 4.1 **Encourage choice and control over health outcomes** by investing in health literacy, awareness of services and access to information<br>4.2 **Engage communities through genuine consultation and shared decision-making** in design of services and sustainable local health service development<br>4.3 **Support culturally appropriate care and cultural safety** for zero tolerance for racism and discrimination in health settings<br>4.4 **Capture patient experience and feedback** and use these insights to improve access, safety and quality of care<br>4.5 **Improve transparency of NSW Health decision-making** and how it is perceived and understood by patients and the community |
| **5. Expand integration of primary, community and hospital care:** Roll out effective, sustainable integrated models of care through collaboration between Commonwealth and NSW Government and non-Government organisations to drive improved access, outcomes and experiences. | 5.1 **Develop detailed designs for expanded primary care models** and trial their implementation in regional NSW through working with the Commonwealth and National Cabinet, Primary Health Networks, Aboriginal Community Controlled Health Organisations, NGOs and other partners<br>5.2 **Address the employer model** to support trainees and staff to work seamlessly across primary care, public, private settings and Aboriginal Community Controlled Health Organisations to deliver care to regional communities<br>5.3 **Improve access and equity of services for Aboriginal people and communities** to support decision making at each stage of their health journey<br>5.4 **Develop 'place-based' health needs assessments and plans** by working closely with Primary Health Networks, Aboriginal Community Controlled Health Organisations and other local organisations including youth organisations and use these to resource services to address priority needs |
| **6. Harness and evaluate innovation to support a sustainable health system:** Continue to transform health services through aligned funding and resourcing models, digital and health technologies, research and environmental solutions. | 6.1 **Align NSW and Commonwealth funding and resourcing models** to provide the financial resources to deliver optimal regional health services and health outcomes<br>6.2 **Fund and implement digital health investments and increase capability of workforce** to deliver connected patient records, enable virtual care, provide insightful health data and streamline processes<br>6.3 **Undertake research and evaluation** with institutions, industry partners, NGOs, consumers and carers<br>6.4 **Commit to an environmental sustainability footprint** for future regional healthcare |

| | Clinical streams | Role of facilities | Ambulatory care | Vulnerable services | Aboriginal health | Older people | MH & AOD |
|---|---|---|---|---|---|---|---|
| **Priority 1: Strengthen the regional health workforce** | | | | | | | |
| 1.1 | ✓ | | ✓ | | | | |
| 1.2 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 1.3 | | | | | ✓ | | |
| 1.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 1.5 | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| 1.6 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Priority 2: Enable better access to safe, high quality and timely health services** | | | | | | | |
| 2.1 | | ✓ | | ✓ | | ✓ | |
| 2.2 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2.3 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2.4 | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| 2.5 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 2.6 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Priority 3: Keep people healthy and well through prevention, early intervention and education** | | | | | | | |
| 3.1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3.2 | ✓ | | | | ✓ | | ✓ |
| 3.3 | ✓ | | ✓ | ✓ | ✓ | | |
| 3.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3.5 | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| **Priority 4: Keep communities informed, build engagement, seek feedback** | | | | | | | |
| 4.1 | | ✓ | ✓ | | ✓ | ✓ | ✓ |
| 4.2 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.3 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4.5 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Priority 5: Expand integration of primary, community and hospital care** | | | | | | | |
| 5.1 | | | ✓ | | ✓ | ✓ | ✓ |

| | Clinical streams | Role of facilities | Ambulatory care | Vulnerable services | Aboriginal health | Older people | MH & AOD |
|---|---|---|---|---|---|---|---|
| 5.2 | ✓ | | ✓ | ✓ | ✓ | | |
| 5.3 | | | ✓ | ✓ | ✓ | ✓ | |
| 5.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Priority 6: Harness and evaluate innovation to support a sustainable health system** | | | | | | | |
| 6.1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6.2 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6.3 | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6.4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

# 4.6 Appendix F – Early options analysis from 2023 round of Capital Investment Proposals

## Lismore Stage 3D

### 1 Issue to be addressed

Lismore is a large regional city, with the Lismore LGA having a population of over 44,000 people in the 2021 Census.[15] The Lismore LGA is the primary catchment for Lismore Base Hospital however the hospital also serves a larger geographic footprint as the main base hospital operating within the Richmond Clarence Network. The Richmond Clarence Network (excluding the Urbenville part of Tenterfield LGA) had a population of just under 178,000 people in 2021.

The Lismore LGA:

- has a significantly ageing population profile, with those aged 70 years and over projected to increase by 32% between 2021 and 2031.[16]
- has a high proportion of Aboriginal and Torres Strait Islander peoples, at 5.9% compared to the NSW average of 3.4%.[17]
- has areas of significant socioeconomic disadvantage, with Lismore at the SA2 level having a decile of 2 (lowest 20%) in the index of relative socio-economic disadvantage (IRSD).[18]

These factors, amongst others, are indicative of people's health and wellbeing across the region, as well as their needs for health services.

Prior to any redevelopment, the majority of Lismore Base Hospital's inpatient wards were in buildings dating back to the pre-1960's. Redevelopment to date has delivered contemporary facilities which are able to meet local demand, deliver best practice models of care, and operate efficiently. The remaining planned redevelopment works would deliver further improvements in patient care and operational efficiency, as well as ensuring a sustainable hospital into the future.

The current issues to be addressed include:

- Ensuring that LBH has sufficient infrastructure and capacity to deliver safe and high-quality healthcare and support services into the future. Over the past five years (2016/17 to 2020/21), inpatient separations have increased by 15% at LBH,[19] and ED presentations by 22%.[20]
- Support services including food services and back-of-house services (loading docks, linen, waste, and stores) are at capacity and operating in significantly aged infrastructure which poses ongoing work health and safety risks and inability to meet compliance standards.

[15] Australian Bureau of Statistics, 2021 Census: https://www.abs.gov.au/census/find-census-data/quickstats/2021/LGA14850 (accessed 01.06.2023)

[16] NSW Department of Planning & Environment, NSW population projections, accessed via CaSPA Portal: https://nswhealth.sharepoint.com/sites/CaSPA-MoH/SitePages/planning-resources.aspx (accessed 01.06.2023)

[17] Australian Bureau of Statistics, 2021 Census: https://www.abs.gov.au/census/find-census-data/quickstats/2021/LGA14850 (accessed 01.06.2023)

[18] Australian Bureau of Statistics, Socio-Economic Indexes for Australia (SEIFA), 2021 (release date 27.04.2023): https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release#index-of-relative-socio-economic-advantage-and-disadvantage-irsad-

[19] NSW Ministry of Health, FlowInfo v21.1. Excl. ED only, episodes entirely as HITH, chemotherapy, renal dialysis, psychiatric and unqualified neonate. Accessed via CaSPA portal: https://nswhealth.sharepoint.com/sites/CaSPA-MoH/SitePages/Home.aspx (accessed 01.06.2023)

[20] NSW Ministry of Health, EDAA v21. Accessed via CaSPA portal: https://nswhealth.sharepoint.com/sites/CaSPA-MoH/SitePages/Home.aspx (accessed 01.06.2023)

- Executive and administration office accommodation is located in a former 1930's nursing quarters which is not fit-for-purpose and has substantial ongoing maintenance costs, exacerbated further by the 2022 floods.
- The dislocation of some services offsite currently leads to operational inefficiency and negatively impacts on service delivery. There is a need to co-locate essential services such as maintenance and clinical information services.
- Flood damage caused in 2022 requires remediation work, as well as adequate strategies and infrastructure to minimise risks of future flooding events. Areas that were impacted include the fleet carpark, pathology and mental health services.

**2 Case for change**

NSW Health is responsible for the delivery of safe, high-value and high-quality health services across the public system. To achieve this, infrastructure needs to meet minimum compliance and safety standards, and there also needs to be a focus on ensuring that support services can meet the needs of an expanding hospital which is servicing increasing patient demand. Current infrastructure at LBH is stretched in areas which have not been redeveloped to date, and this is creating inefficiencies in service delivery and has associated and ongoing maintenance and remedial works costs. Some infrastructure has reached end of life and NSW Health would benefit over the longer-term from investing in the final stages of LBH redevelopment as this would deliver a sustainable solution for the system and patients.

**3 Analysis of 'base case'[21]**

If there was no change in current practice, population factors or demand, the following outcomes are likely:

- Reduced capacity to meet increasing patient demand and provide services required to support the planned expansion in bed capacity.
- Reduced capacity to implement contemporary models of care.
- Reduced sustainability and efficiency of operational and support services.
- Limited opportunity to improve the responsiveness of the facility (such as in relation to disaster events such as flooding).
- Inability to capitalise on operational and support service adjacencies due to aged and dislocated infrastructure and associated teams.
- Ongoing high costs of required maintenance and remedial works as well as continued non-compliance with some current health facility guidelines and building codes.
- Ongoing impact on overall financial position and future financial sustainability as resources are directed inefficiently and to areas with a short-term focus.
- Ongoing and avoidable work health and safety risks.
- Reduced ability to deliver safe and high-quality health services as support services are fragmented, running from inadequate infrastructure and lack appropriate staffing levels.
- Difficulties in recruitment and retention of staff due to lack of amenities and work health and safety risks.

**4 Identify and develop a 'long-list' of options to address the issue**

- Reduce the initial scope of the redevelopment and do not complete any part of stage 3D, meaning no further development works. This option would be maintaining the current status quo and conducting only necessary maintenance and replacement works as required.

[21] The 'Base Case' assumes 'no change' to current trends in the population, operating budgets and models of care continue, or 'no intervention' to how things are currently done.

- Reduce the scope of stage 3D of the redevelopment, excluding the demolishing and rebuild of Crawford House. This would instead necessitate the need for leasing of premises for office accommodation.
- Continue with stage 3D redevelopment works, including developing a revised master plan to deliver contemporary options and costings. This would incorporate two options:
    - Redevelop and refurbish on the existing LBH site.
    - Redevelop and refurbish on the existing LBH site as well as considering off-site options for some aspects of the scope of works.
- Utilise existing infrastructure and undertake smaller scale refurbishment works to deliver updated office accommodation, inpatient units and food services, while maintaining some services off-site (e.g., clinical information services).
- Relocate services that are LHD-wide or non-specific to LBH to reduce the required redevelopment works, including the relocation of executive and administration offices and clinical information services. This option would require remaining within the vicinity of LBH, with Ballina being a potential option.
- Consider options for outsourcing certain services so they are not required to be managed by the LHD/shared services (e.g., HealthShare) or co-located on-site (e.g., back of house services).
- Partner with private developers to undertake required redevelopment works, reducing initial cost outlay but adding future structures of leasing arrangements cost and/or buy-back options.

## 5 Qualitatively analyse the long list

| Who | Description of option | Effective | Sustainable | Capital/infra structure implications | Benefits | Costs | Comments |
|---|---|---|---|---|---|---|---|
| NNSW LHD | Maintain status quo, no further works. | No | No | No | Low | Low | Not viable due to current WH&S risks; non-compliance with building and health facility standards; displacement of staff and services following floods; low efficiency; lack of capacity to meet patient demand. |
| NNSW LHD / Health Infrastructure | Redevelop as planned to deliver stage 3D, with a contempoary master plan providing options for best approach. | Yes | Yes | Yes | High | High | High cost but will deliver a sustainable long-term solution that meets the needs of the hospital, LHD and community. As a large and growing regional area of NSW, there is a strong need to be able to continue to deliver high-quality, safe and high-value health services from LBH. |
| NNSW LHD / Health Infrastructure | Redevelop but reduce scope of stage 3D. | Partial | Partial | Yes | Medium | Medium | This option would provide some benefit through refurbishment works; however, some services would need to remain or move off-site, menaing ongoing leasing costs and associated instability. There would also be high ongoing maintenance costs and risks associated with current capital. |
| NNSW LHD / private market | Redevelop to full scope of stage 3D, in partnership with the private market | Yes | Yes | Yes | High | Medium - high | This option provides high benefit at a lower initial cost; however, ongoing costs through leasing or buy-back arrangements would compound over time, making this a less sustainable option financially. There would also be greater risk on NSW Health in relation to potential shared use arrangements. |

## 6 Choice of preferred option

The preferred option is continuing with planned redevelopments at LBH to deliver stage 3D. Given the period between initial planning and delivery of this staged redevelopment, an updated master plan would be required to determine contemporary options and costings. This option would address the issues outlined and would deliver a sustainable long-term solution for the LHD, including:

- offers a long-term sustainable solution which eliminates the need for ongoing remedial and maintenance works on the current aged buildings and infrastructure, some of which do not meet minimum specifications and present work health and safety risks.
- creates greater efficiencies through co-locating essential services, expanding the footprint of essential services, and designing infrastructure which is fit-for-purpose and supports contemporary work practices.
- delivers contemporary infrastructure which will support the implementation of best practice models of care that will improve patient flow, hospital operational function, care delivery and patient and staff experience.
- supports workforce recruitment and retention.
- supports the achievement of longer-term financial sustainability.
- enables a considered design approach which is cognisant of environmental factors, including flood zones and the likelihood of future flood emergencies in Lismore.

## Staff accommodation

### 1 Issue to be addressed

The key demographic features that will impact upon the health status and health service use of the catchment populations are significant projected population growth, a large and growing aged population, large pockets of low socioeconomic status, and a high proportion of Aboriginal residents. The ability to attract and retain appropriate levels of staff across the LHD is a significant challenge that is compounded by low housing supply and high costs.

The current issues to be addressed include:

- inadequate supply of appropriate housing to accommodate the staff required for the functional operation of the new Tweed Valley Hospital, as well as to maintain appropriate staffing levels at Grafton and Lismore Base Hospitals
- high cost and instability of current leasing arrangements which includes a mix of unit/house leases, motel booking and other short-term booking options such as Airbnb. Additional costs include cleaning, real estate fees, furniture removals, and high administrative costs for LHD staff in sourcing and managing bookings.
- very limited option for securing further leases due to near zero vacancy rates
- difficulties in staff recruitment and retention due to tight housing market
- difficulties in meeting LHD requirements to provide adequate accommodation for key workers, including JMO's
- potential political and media difficulties if the new TVH is unable to be opened with the planned range of services which have already been communicated

### 2 Case for change

NNSW LHD needs to attract and retain adequate levels of suitably qualified staff to be able to effectively and efficiently operate health care services. The current lack of adequate housing options across the greater Tweed, Lismore and Grafton regions is creating recruitment difficulties as well as challenges for the LHD in meeting its obligations to provide accommodation for key workers.

It is recognised that there are a broad range of structural and societal issues that impact the housing supply market and that this typically falls outside the purview of NSW Health. However, NSW Health is required to meet its obligation to provide certain amenities for workers, including accommodation for key groups of staff. The need for key worker accommodation is a critical issue that NSW Health needs to address to ensure the ability to deliver essential health services.

### 3 Analysis of 'base case'[22]

The base case scenario is to continue with the current accommodation arrangements, which includes a mixture of a small supply of accommodation owned by NNSW LHD, leasing of units/houses, and short-term arrangements through hotels/motels/Airbnb.

The real and/or possible outcomes of this scenario include:

- ongoing high annual cost with no longer-term capital / residual benefit
- escalating costs over time, driven by the market

[22] The 'Base Case' assumes 'no change' to current trends in the population, operating budgets and models of care continue, or 'no intervention' to how things are currently done.

- inability to scale the current arrangements due to market constraints
- administratively burdensome approach to identify and book short-term accommodation options such as hotels, as well as to negotiate and manage leases
- potential for leases to end with an inability to secure other appropriate accommodation options
- inability to secure an adequate number of accommodation spaces to meet staffing needs
- inability to attract and retain the required workforce to staff hospitals to the levels required to deliver current and planned services
- for the Tweed, accessibility to the new TVH will be challenging as the current leased options are a minimum 20-minute drive from the hospital. This is not suitable for on-call staff and for those without a private vehicle as there is very limited public transport options.

**4 Identify and develop a 'long-list' of options to address the issue**

- Continue to lease a range of accommodation (including units/houses and hotels/motels) for key workers.
- Capital development of accommodation for key workers on a site which is owned by the Health Administration Corporation (HAC) (e.g., TVH option) or other NSW Government agencies (e.g., Lismore option).
- Capital development of accommodation for key workers on an alternate site.
- Advocate for investment in improved public transport options so viable leasing options can be expanded across a broader geographic area.
- Advocate for the limiting of holiday letting so there is greater availability of accommodation for long-term lease.
- Greater investment in housing development in the Tweed Valley, Lismore and Grafton regions to deliver greater housing supply for lease.
- Purchase of already built accommodation options, for example, a large block(s) of units.
- Purchase and use of temporary accommodation options, such as pods or mobile homes.
- Capital development of accommodation for key workers in a public-private partnership model.

**5 Qualitatively analyse the long list**

| Who | Description of option | Effective | Sustainable | Capital/infra structure implications | Benefits | Costs | Comments |
|---|---|---|---|---|---|---|---|
| NNSW LHD | Continue current leasing arrangements. | Partial | No | No | Medium | Low | Lower cost in the short-term however will compound over time and is unsustainable from a cost and effectiveness perspective. Very tight rental market makes this option unviable for required accommodation volumes. |
| NNSW LHD / Health Infrastructure | Capital development of accommodation on site owned by HAC/other NSW Gov agency, and refurb of Grafton Correctional Centre. | Yes | Yes | Yes | High | High | Whilst a high initial capital outlay, this option will deliver efficiencies due to its long-term sustainability. This option utilises Crown land which has cost benefits and in the Grafton location, utilises already built infrastructure. |
| NNSW LHD / Health Infrastructure | Purchase of already built accommodation option (e.g. block(s) of units). | Yes | Yes | Yes | High | High | This option would be a high capital cost and the LHD would be unlikely to secure sufficient accommodation to meed need. |
| Non-health | Greater investment in housing development in the region. | Yes | Yes | No | High | Low | This is an important and viable option to address housing shortages in the region however is outside of the LHD's control. |

## 6 Choice of preferred option

The preferred option is for each location is:

- Tweed: a capital development of purpose-built accommodation on the site already owned by the HAC.
- Lismore: capital development of purpose-built accommodation on an appropriate site, potentially one already owned by the NSW Government.
- Grafton: refurbish Grafton Correctional Centre into group accommodation and multi-bedroom apartments.

These options provides a sustainable solution that meets the needs of the LHD, including:

- offers a long-term sustainable solution
- supports the LHD in meeting corporate policy, including the provision of accommodation for JMO's
- complies with HETI accreditation standards; LHD, NSW Health and medical college policies; and considers the needs of families
- provides adequate staff amenities for on-call staff
- eliminates ongoing leasing costs which have no future capital / residual value for the LHD
- reduces risks relating to the local property market (e.g. inability to secure an adequate volume or standard of accommodation)
- supports all three facilities in recruitment and retention efforts and the ability to be staffed at appropriate levels to be fully operational and safe
- enables a staged development approach in alignment with demand
- offers opportunities for varying procurement models and potential for revenue streams

## Urbenville MPS

### 1 Issue to be addressed

The Urbenville MPS provides a critical service to Urbenville and surrounding communities, delivering services to residents of the Urbenville and Kyogle LGAs and visitors to the area. The key demographic features that will impact upon the health status and health service use of the catchment population are:

- a high proportion of people aged 70 years and over (20% of the population compared to NSW average of 12%)[23]
- an ageing population, particularly in the 85 years and over age group (projected to increase by 19% between 2021 and 2031)[24]
- a significant Aboriginal population, estimated at 14.5% in the 2021 Census (compared to 3.4% for NSW)[25]
- a high level of disadvantage, with the catchment region in the lowest ABS IRSD quintile[26]

The current issues to be addressed include:

- Considerably aged and inadequate capital and equipment infrastructure to deliver high-quality and high-value care despite ongoing maintenance efforts.
- Inefficient and under-sized treatment spaces, and a sub-optimal layout leads to poor functionality.
- High cost of temporary repairs is not a viable or cost-effective solution.
- Inadequate infrastructure will not support a demand-driven approach to aged care provision.
- Considerable occupational health and safety risks for staff and public access, particularly the older population.
- Inadequate specified aged care places for Aboriginal people, nor are there culturally appropriate waiting spaces for this population.
- Limited availability of alternative primary care options, general practice and non-government health services.
- Inability to access the mix of health and aged care services appropriate to the needs of the community due to isolation and long distance to the closest higher-level facility.
- Difficulties in staff recruitment due to poorly functioning clinical areas and overall infrastructure.

### 2 Case for change

NNSW LHD needs to support the implementation of the MPS model due to the geographic and demographic characteristics of Urbenville and the surrounding region. There is insufficient catchment population to sustain separate acute hospital, residential care, community health and home care services.

[23] Australian Bureau of Statistics, Census 2021 Quickstats (accessed 15.06.2023)

[24] NSW Department of Planning and Environment, 2022 CPA Population Projections, accessed via the Clinical Services Planning and Analysis (CaSPA) Portal, accessed on 13.03.2023

[25] Australian Bureau of Statistics, Census 2021 QuickStats, accessed 15.06.2023

[26] Australian Bureau of Statistics (2016). Socio-Economic Indexes for Areas: 2033.0.55.001 - Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016 (abs.gov.au)

The current lack of adequate capital and equipment infrastructure will not support the demand driven access to aged care which has been recommended in the Royal Commission into Aged Care Quality and Safety. There are also challenges with continued service delivery across inpatient and community services due to significantly aged infrastructure and inefficient spaces which impact on operations and patient care delivery.

Service demand, rising costs, and the requirement for services and models of care to be age-specific, with a particular focus on older persons, is presenting challenges for the LHD in meeting its obligations to provide the region's ageing population with high quality care. The need for the Urbenville MPS redevelopment is a critical issue that NSW Health needs to address to ensure the ability to support timely and equitable access to appropriate care for the population of Urbenville and surrounds.

**3 Analysis of 'base case'[27]**

The base case scenario is to continue with the current MPS that provides ED, inpatient, community and both residential and community aged care services. Within the current infrastructure, the MPS has 18 high care residential aged care bed places and offers six community aged care packages. This supply of places has remained relatively unchanged over the past number of years despite the ageing population.

The real and/or possible outcomes of this scenario include:

- Inability to meet the healthcare needs of the surrounding community, particularly as the population continues to age and there are increases in complex and comorbid conditions.
- Lack of ability to deliver primary care type services to the community.
- Inability for older patients to travel long distances to other health services.
- Increased complexity of patient care and/or an inability to discharge earlier due to inadequate options for discharge, such as aged care placement at an alternate residential facility.
- Lack of ability to provide culturally appropriate waiting spaces and aged care places for Aboriginal people.
- escalating and inefficient operating and maintenance costs.
- Increased workplace risks due to the age and damage to existing infrastructure, disrupting fire and smoke walls.
- Inability to recruit due to poorly functioning clinical areas.
- Potential future structural impacts due to subsidence problems and major foundation issues.
- Inability to protect infrastructure from impacts of climate change, for example bush fires.
- Potential future environmental impacts.

**4 Identify and develop a 'long-list' of options to address the issue**

- Continue with the current infrastructure of 18 high care residential aged care beds and 6 community aged care packages, three ED treatment spaces, four acute inpatient beds and primary and community health consultation space. This option would entail ongoing repair and maintenance costs so the MPS is safe and operational.
- Close the Urbenville MPS and transfer community and aged care services to nearby towns. ED and inpatient services would cease in Urbenville, with patients needing to travel to an alternate facility, the closest being Bonalbo MPS (36kms / 36mins by car).
- Demolish existing structures and invest in capital development of an MPS on the current site.

[27] The 'Base Case' assumes 'no change' to current trends in the population, operating budgets and models of care continue, or 'no intervention' to how things are currently done.

- Invest in capital development of an MPS on an alternate site. This option would allow for the demolition of the current MPS (meaning the land could potentially be sold), keeping the building structure and selling as is, or re-purposing the building structure for another public health service.
- Fund a mobile health clinic to boost access to primary health care services for those people who face an increased risk of developing preventable diseases or conditions.
- Deliver higher levels of community-based care and HITH, including nurse-led home care teams, to reduce demand on acute services.
- Partner with other organisations, like NGOs, to provide health care and outreach services for people in need.
- Work in collaboration with partner organisations (including PHN, NGOs and other government departments) to improve health literacy and increase investment in health promotion.
- Work in collaboration with partner organisations (including PHN, NGOs and other government departments) to promote healthy living and lifestyle choices as well as early intervention to support reductions in chronic disease over the longer-term.
- Advocate for greater investment in improved public transport options in the Richmond Valley region to deliver services to the ageing population.
- Advocate for greater investment in improving the country roads that have deteriorated due to natural flood disasters.
- Advocate for private investment in the MPS to redevelop the residential aged care space (likely a private aged care provider).

**5 Qualitatively analyse the long list**

| Who | Description of option | Effective | Sustainable | Capital/infra structure implications | Benefits | Costs | Comments |
|---|---|---|---|---|---|---|---|
| NNSW LHD | Maintain status quo / keep safe and operational | No | No | No | Low | Low | Low cost however ongoing required maintenance and repairs costs will compound over time. This option is not sustainable and will result in sub-optimal patient care and operational service delivery. |
| NNSW LHD / Health Infrastructure | Close the MPS and transfer services to nearby towns. | Partial | Yes | Yes | Medium | Medium | Costs would be related to service transfer and potential demolition. There could be cost offsets through sale of land/assets. Benefits limited by geographic isolation of Urbenville and difficulties in accessing healthcare services in surrounding areas. This option would not be politically palatable and would not deliver on requirements under the MPS model. |
| NNSW LHD / Health Infrastructure | Redevelop the MPS on the current site | Partial | Yes | Yes | High | High | This option would eliminate the cost of land acquisition; however, will still be high capital cost due to demolition. There is also potential for ongoing high maintenance costs due to the geotechnical issues which have already been identified on the current site. |
| NNSW LHD / Health Infrastructure | Redevelop the MPS on a greenfield site | Yes | Yes | Yes | High | High | This option has been estimated at a lower cost than redeveloping on the current site. There are land acquisition costs however these would be offset. This option provides the most effective and sustainable long-term solution. |
| NNSW LHD / partner organisations | Fund a mobile health clinic to provide outreach services to Urbenville and surrounds | Partial | Partial | Yes | Low | Low | Capital costs would be low and related to the purchase and running of a mobile service. This option would only be suitable for a particular patient cohort (e.g. primary care type and community health) and would not deliver large benefits at scale. There is also the potential for patients to be diverted from the mobile clinic to other hospitals (e.g. Lismore) which moves demand to already stretched facilities. |

## 6 Choice of preferred option

It is proposed that Urbenville MPS be redeveloped on a greenfield site to provide infrastructure that is structurally sound and is equipped to deliver contemporary healthcare services that meet the needs of the rural Urbenville and surrounding communities. As an MPS, this will include continued emergency department, inpatient, and community health services alongside residential and community aged care. Redevelopment is also an opportunity to potentially co-locate with the Urbenville NSW Ambulance service.

This option provides a sustainable solution that meets the needs of the LHD, including:

- Offers a long-term sustainable solution.
- Offers a more environmentally sustainable build and whole of life cycle costs that increase efficiencies as well as minimise future environmental impacts.
- Alignment with recommendations from the Royal Commission into Aged Care Quality and Safety as well as NSW Health operational guidelines.
- Supports the inclusion of innovative aged care models, including for Aboriginal residents.
- Supports the LHD in meeting corporate policy, including the provision of healthcare services that are demand-driven.

- Complies with HETI accreditation standards and broader NSW Health standards.
- Provides adequate treatment spaces and promotes better quality of life for residents.
- Eliminates significant maintenance costs on ageing infrastructure which have no future capital / residual value for the LHD.
- Reduces risks relating to the poorer health outcomes, greater health needs and challenges with affordability of transport to other areas for health services and considers the needs of families.
- Supports recruitment of staff at an appropriate level to be safety operational.
- Enables a staged development and commissioning approach in alignment with demand.
- No adverse impact on services in nearby towns.
- Supports the capacity to achieve financial viability under MPS funding arrangements.
- Allows for consideration of potential future pandemic or other public health events by improving the physical layout.
- Delivers a fit-for-purpose design that meets the needs of patients and staff, as well as supporting optimal delivery of models of care.

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