Special Commission of Inquiry into Healthcare Funding

Statement of Matthew Jennings

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

2. This statement is provided in response to a letter of 24 May 2024 issued to the Crown Solicitor's Office and addresses the topics set out in that letter relevant to my role.

A. INTRODUCTION

3. My name is Matthew Jennings. I am the Director Allied Health at Liverpool Hospital, South Western Sydney Local Health District (**SWSLHD**), a role I have held since 2013. In this role, I am on the executive leadership team and directly manage allied health staff. I am responsible for leadership and management of allied health services, including:

   a. operational governance and financial management

   b. clinical service delivery and patient safety and quality systems

   c. human resource management

   d. clinical supervision and professional development

   e. fostering a culture of evidence-based practice and innovation to deliver improved health outcomes and experience, and

   f. risk management and work, health and safety.

4. In addition to my 0.5 FTE Director Allied Health role, I was appointed as Director Physiotherapy, SWSLHD, from 2013 to 2023. In this role, I was responsible for physiotherapy staff and services across SWSLHD, including professional governance, strategic leadership, development of models of care and service delivery, and support for research and implementation projects, including funding opportunities to meet SWSLHD priorities.

5. Before my appointment as Director Allied Health at Liverpool Hospital, I held various Physiotherapy positions in SWSLHD, including from 2006 to 2009 as Deputy Head of Department, Physiotherapy, Liverpool Hospital; and Director Physiotherapy, SWSLHD from 2009 to 2012. In addition, I have acted as General Manager, Liverpool Hospital for short periods since 2018, and acted as Director of Allied Health and Community Services, SWSLHD, for a combined total of approximately 5 months from 2022 to 2024. In 2023, I was seconded for 9 months as Program Manager, Whole of Health Collaborative, SWSLHD. A copy of my curriculum vitae is at **Exhibit A**.

6. Additionally, I have been a Co-Chair of the Agency for Clinical Innovation (**ACI**) Musculoskeletal Network since 2012. The purpose of the Musculoskeletal Network is to bring together clinicians, health managers, consumers and other relevant stakeholders to review, design and implement new ways to improve the healthcare experiences and outcomes for people with musculoskeletal conditions in NSW, including developing and evaluating new models of care for such conditions.

B. NEW MODELS OF CARE

(i) Identifying new models of care

7. "Models of care" simply mean the ways in which health services are to be provided to patients. They aim to outline best practice for patient care with reference to relevant scientific evidence, and provide direction on delivering health outcomes that are important to patients and the health system. More recently, Co-Chairs of ACI were consulted in the development of the 2024 draft *Principles for developing models of care,* that are currently out for broader NSW Health consultation. The ACI approach has evolved with regards to an Adopt, Adapt, Collaborate or Lead strategy that is aimed at reducing effort and duplication and maximising the identification and uptake of existing evidence based best practice models of care.

8. New statewide models of care in NSW are, broadly speaking, generated by engaging relevant stakeholders and seeking input from a number of different sources, but are in large part developed by the ACI. In my experience as Co-Chair of the Musculoskeletal Network, I have led and overseen the identification, development and implementation of a number of models of care for people with musculoskeletal conditions. These include the Osteoarthritis Chronic Care Program: Model of care (**Exhibit B**), Model of care for osteoporotic refracture prevention (**Exhibit C**) and the Management of people with acute low back pain model of care (**Exhibit D**). The starting point for the identification of a new model of care is the development of a case for change following identification of gaps in

patient care outcomes or experience, or a disconnect between care delivery and available best practice evidence.

9. Once the development of a proposed statewide model of care is endorsed, networks will engage relevant experts and conduct a scoping review of evidence. The process is guided by documents, including the ACI Understanding the Process to Develop a Model of Care: ACI Framework (MOH.0001.0283.0001). This was published as a practical guide on how to develop a Model of Care. The individuals engaged in the process will depend on the nature of the care gap or issue that is being looked at. For example, the Osteoporosis Refracture Prevention Model of Care required input from multiple medical specialty teams including endocrinology and rheumatology, geriatrics, orthopaedic surgery, emergency physicians, allied health, pharmacy, radiology, primary care, consumers and consumer organisations, health managers, policy experts and others.

10. In a similar fashion, the identification of the need for new models of care within LHDs often involves clinicians and LHD staff identifying clinical variation or local gaps in care or outcomes. This may occur through regular governance committees, review of patient reported outcomes and experience measures, or the reporting of population level health outcomes. The strategic and clinical service planning processes at state and LHD level also support consultation on service delivery models. In SWSLHD, the various clinical streams provide recommendations on potential new models of care and the strategic care direction to be set out in such plans. For example, the SWSLHD Older Persons and Rehabilitation Plan to 2027 (**Exhibit E**) highlighted the need for implementation of community geriatric outreach models and early in-reach rehabilitation models within acute hospitals.

11. Additionally, the SWSLHD Advance Care Planning, End of Life & Palliative Care Strategic Plan 2016 – 2021 (**Exhibit F**) provided the direction for change, and the actions that are needed, to ensure the best care and support is provided for people at the end of their life.

12. The LHD also utilises statewide plans such as the NSW Health End of Life and Palliative Care Framework 2019-2024 (**Exhibit G**) to support the development and implementation of local models of care, taking into account local context and community needs. For example, the Neurodegenerative Disease Supportive Care service in SWSLHD was developed and sought targeted funding to deliver improved outcomes and experience to people with late-stage degenerative disease.

(ii) Evaluating new models of care

13. The development of any new model of care requires an evaluation framework to be agreed at the development stage. The evaluation is based on the quadruple aim, being health outcomes that matter to patients, experiences of receiving care, experiences of providing care, and effectiveness and efficiency of care. Although the nature of that evaluation and individual measures of success will depend on the model of care and the specific outcomes it is seeking to address.

14. The development of an evaluation plan is often supported by the ACI Clinical Redesign and Evaluation teams. The selection of relevant outcome measures is informed by evidence and guided by clinical registries, the Australian Commission on Safety and Quality in Health Care clinical care standard indicators, the International Consortium for Health Outcomes Measurements (ICHOM) and other specialty specific recommendations.

15. The ACI Musculoskeletal Network is committed to evaluating outcomes and impact, as demonstrated in the production of frameworks to support the evaluation of models of care and publications on the implementation of models to support value-based care. An example is A Framework to Evaluate Musculoskeletal Models of Care (**Exhibit H**) which was publicly supported by 44 organisations, and the 2020 journal publication *'Implementing models of care for musculoskeletal conditions in health systems to support value-based care'* (**Exhibit H**). In summary, it concludes value based healthcare is supported by models of care "adopting evidence-based clinical pathways and protocols, aligning incentives, effectively managing resource, continuously monitoring and improving performance, and investing in supporting information technologies".

16. Statewide models of care, being those developed by ACI, are evaluated in accordance with pre-defined success measures, inclusive of health outcomes as well as data on cost effectiveness and resource use. Evaluation may be guided by program logic and evaluation frameworks developed by NSW Health or ACI evaluation teams. This will often include additional implementation and process measures, or proxy measures such as clinic or surgical activity or incentive-based targets. For example, the use of patient reported measures as part of Value Based Healthcare initiatives or National Weighted Activity Unit (**NWAU**) activity and patient numbers enrolled in Renal Supportive Care programs. A similar evaluation approach is undertaken for LHD-developed models of

care and clinical redesign projects that look to implement models of care or service delivery improvements.

17. There are evolving challenges for the evaluation of new models of care, including efficient and accurate collection and measurement of patient level data, particularly in the context of:

    a. models of care focused on integrating primary and community-based care

    b. longitudinal outcomes that are supported by primary and secondary prevention, and

    c. patient reported experience and outcome measures (**PRMs**).

18. The collection and measurement of PRMs and system level data is a work in progress. It requires planning during the development and implementation phase of a new model of care and proper consideration of what is important for patients. However, it can still be difficult to track and accurately represent the impact of individual interventions and components of care delivery on outcomes, as patients move across different care settings. For example, when people move from acute hospital care to and from primary care, or when there is a lack of timely access to rehabilitation or aged care services. Outcomes are also influenced by health literacy, adherence and the uptake and delivery of recommended care, and inequity of access to post-acute and ambulatory care health services. Following transfer of care there is also suboptimal measurement of the health interventions that are provided in primary care and across public and private spheres.

19. In addition, health outcomes are influenced by broader social determinants including accessibility and affordability of access to public and private health services, housing, environment and social supports. An example of the challenge in measuring patient outcomes is measuring the longitudinal impact of hospital avoidance through falls prevention strategies or osteoporotic refracture prevention models. The real impact of a model of care focused on secondary prevention is complex and difficult to measure. It requires accurate projection of expected admission rates for falls and fracture, and consideration of changes in population growth and ageing. LHDs often seek immediate demonstration of impact or return on investment through a reduction in emergency presentations or hospital admissions for a particular condition.

20. In reality, as healthcare demand is increasing, the goal should be to flatten the growth in cost and demand through high value care rather than reduce activity. Assessment of success that is based only on real reduction in activity may be inappropriate and

counterproductive. In SWSLHD, for example, it is not realistic to set an expectation to reduce fracture presentations in older people when the number of people over 65 years is significantly increasing in the community. Similarly, setting public hospital targets to limit raw elective joint replacement numbers would not be equitable given the need, and comparing LHDs with a higher proportion of people with private health insurance and private hospital access to those LHDs where the local community is highly reliant on public hospital surgery waitlists is inherently unfair. Patient reported outcomes and standardised system measures will continue to assist evidence informed decision making and investment. The ongoing maturing and improvement in system evaluation is required to better address equity issues, including consideration of influencing factors such as comorbidities, levels of disability and the incidence of conditions such as dementia and diabetes in the community.

21. Longer term monitoring of health outcomes for target groups could be achieved if data from primary care was more easily linked to acute care hospital data. I understand the development of NSW Health Data and Analytics Strategy and the introduction of the Single Digital Patient Record (**SDPR**), is attempting to address the known data sharing and privacy barriers within the system. The primary goal is to bring together various sources of information to support patients within the NSW Health system. In order for the SDPR to be effective in assisting future evaluation of new models of care, the SDPR reporting functions require further development, staff need to be appropriately trained, and resources provided to easily extract, analyse and utilise the system data to inform care delivery and identify variation that requires service delivery improvement.

(iii) Funding new models of care

22. A range of funding mechanisms are used to support the implementation of new models of care in NSW and SWSLHD. These include:

    a. Targeted funding arrangements: Dedicated recurrent or pilot project funding from the Ministry of Health, the ACI, or another funding body, to address specific areas of need. LHDs are usually required to submit expressions of interest or business case requests to access funding to support implementation. For example, Geriatric Outreach, Leading Better Value Care, and Enhancing End of Life Care initiatives.

    b. Activity Based Funding (**ABF**): the Ministry of Health may provide support through activity targets to incentivise new models of care, including the creation of a new ABF clinic code or project mapping within annual District Service Level Agreements or

through separate funding allocation. However, as the ABF model incentivises NWAU activity, innovations focussed on preventative, multidisciplinary care, and ambulatory and out of hospital care models can be disadvantaged by the lower NWAU value given for non-admitted care delivery. LHDs find it difficult to redistribute resources from acute to non-admitted and community services due to the ongoing and increasing demands on hospital level care related to population growth and an ageing population. This is further exacerbated in SWSLHD by inequity of access to primary care (general practitioners), private health options, lower health insurance uptake and the impact of known sociodemographic challenges in SWSLHD.

c. Translational Research Grants (**TRGS**) and other relevant grant opportunities: The TRGS and other National Health and Medical Research Council (**NHMRC**) grant rounds also provide NSW Health staff opportunities to robustly pilot and implement models of care and evaluate impact on health system and health outcomes. The ACI networks often assist to identify partners, direct attention to areas of need and support piloting and scalability of successful projects.

23. Funding arrangements for new models of care could be improved by:

a. reviewing non-admitted patient funding mechanisms

b. incentivising a movement to preventative health care, and

c. looking at value-based healthcare and other outcome-based measurements, whilst also ensuring that local population factors and equity issues are effectively managed.

24. Funding and the allocation of investment by NSW Health and individual LHDs into best practice models of care could also be improved through the ongoing review of workforce and workforce modelling. Evidence based care guidelines, PRMs and system outcome measures should inform our workforce enhancements and investment decisions.

25. I believe that, unfortunately, historic funding and existing workforce profiles are too often used to determine new expenditure, and this tends to focus on individual discipline groups, and primarily on staff that are clinical facing, such as medical and nursing. Efficiencies and outcome improvements related to investment in corporate and support services and multidisciplinary care can easily be overlooked. For example, initiatives such as Nursing Hours per Patient Day (NHPPD) ratios and the new Safe Staffing Levels (SSL) may be designed to address safety and demand, although in the absence of any funding mechanism to balance other service needs and gaps, there can be unintended

consequences such as an overly generalised approach to ward staffing requirements, independent of complexity. Due to finite resources, additional investment in one care setting or discipline will result in lack of growth in other parts of the health workforce.

26. Ideally, if barriers impacting bed capacity and poorer outcomes are related to medical workload, the lack of early rehabilitation input or the need for rapid access to diagnostics, then the appropriate solution would be investment in junior medical or allied health workforce, or equipment to support improved outcomes. In a similar way, if bed days are excessive due to extended waiting times for theatre or procedural care, then a value-based initiative would look to increase theatre productivity rather than increase costs associated with the staffing of additional beds.

27. The appropriate support to care for people who are not fluent in speaking English as well as those from priority populations is another factor that should be considered in review of funding mechanisms.

(iv) Examples of new models of care in use or under development and future planning

28. During my time as Co-Chair of the ACI Musculoskeletal Network, the Network developed a number of models of care:

a. The Osteoarthritis Chronic Care Program aims to optimise early assessment and intervention for people with hip and knee osteoarthritis to maximise quality of life, optimise people's fitness prior to surgery and remove people from waitlists or delay the need for surgery when appropriate

b. The Osteoporotic Refracture Prevention model of care aims to identify people with minimal trauma or fragility fractures and ensure early multidisciplinary assessment and management to prevent further fractures

c. Other examples include the Management of people with acute low back pain Model of Care and the Paediatric Rheumatology Model of Care (**Exhibit K**).

29. In addition, as part of the ACI Musculoskeletal Network and within my Allied Health role in SWSLHD, I have been engaged with and supported the Palliative Care Network, Frailty Taskforce, Aged Care Network, Pain Network, Rehabilitation, Renal Supportive Care, and several other ACI models of care.

30. At SWSLHD, I am aware of several models of care in use or being developed, including Leading Better Value Care and local initiatives. For example:

    a) Renal Supportive Care: providing patients with shared decision making and care options regarding dialysis and intervention to assist them managing their condition.
    b) Geriatric Outreach Services, the Community Older Persons Intervention and Liaison Outreach Team (COPILOT) and multiple rehabilitation models of care, including in-reach teams and rehabilitation in the home.
    c) Osteoarthritis Chronic Care Program, Osteoporosis Refracture Prevention, High Risk Foot Services, Hip Fracture and Direct Access Colonoscopy.
    d) Movement Disorders and the Neurodegenerative Supportive Care Service.

31. Although not a model of care in and of itself, virtual care is considered a system enabler and is increasingly used as a method to improve efficiencies in new models of care. Many new models of care now utilise a 'hybrid' model, where an initial face to face appointment is followed up via telephone or video consultation. For example, our recent study demonstrated that a hybrid model for remotely delivered physiotherapy with support via phone, text and an app is as good as face-to-face physiotherapy for the management of musculoskeletal conditions. Another example of innovative piloting of virtual rehabilitation care was a multicentre trial conducted in SWSLHD using digitally enabled aged care and neurological rehabilitation to enhance outcomes with activity and mobility using technology (the AMOUNT trial). The study demonstrated improved mobility in people with a wide range of health conditions making use of digitally enabled rehabilitation.

C. CLINICAL INNOVATIONS

(i) Assessment and approval of clinical innovations

32. Clinical innovation is a broad term and I consider it to mean any clinical intervention or service delivery improvement as well as the testing of novel ideas through to the embedding of research evidence into clinical practice. As such, it can cover centralised, statewide projects as well as local decentralised innovations. For example, the implementation of the NSW Telestroke Service or the Diabetes High Risk Foot Service Model of Care are high level statewide initiatives. The Aged Care Rapid Assessment and Investigation Unit (**ARIA**) model at Liverpool Hospital is an excellent example of a local innovation and model of care, underpinned by evidence for acute and rapid geriatric and

multidisciplinary team assessment for older people that present to hospital with acute conditions. The ARIA model was first implemented as a local pilot project and then was a recipient of the NSW Health Award.

33. In terms of the approval of clinical innovations, this ranges from formal research and ethics governance mechanisms to more informal and frontline local quality improvement project submissions. The latter may receive manager, facility or LHD based project approval. Clinical Redesign and other formalised improvement science or team-based project applications are more formally assessed by the LHD Clinical Governance Unit or executive leadership committees with expressions of interest often endorsed by Chief Executives.

34. At a statewide level, the assessment of clinical innovations and the impact or success will be measured through review of the evidence or data and improvement in patient outcomes. Although some clinical innovation initiatives identify their primary purpose as efficiency and cost effectiveness, the move towards value-based healthcare ensures clinician and consumer involvement, as well as PRMs, are included in the assessment of new clinical innovations. The optimal outcome is when a model of care or innovation improves outcomes and experience along with other system benefits, including workforce and or cost efficiencies. In my experience, ensuring consumer and clinician engagement is central to the process and is the best way to make sure that outcomes remain relevant, and the potential for budgetary constraints alone to drive investment decisions is minimised.

35. The Musculoskeletal Network has a long involvement in developing clinical innovations. It is by its nature, multi-disciplinary, and clinical engagement is seen as critical for the success of the assessment and uptake of clinical innovations. Apart from clinicians, the Network involves consumers as equals, including both individuals and consumer group representatives such as Arthritis Australia. The Network may also look to prioritise involvement in a particular area due to the need for a complex solution. For example, the Paediatric Rheumatology Model of Care may not be addressing issues at the same scale as other musculoskeletal conditions, however, the complexity of providing timely and quality specialist services to vulnerable and high-risk children was seen as a Network priority. The Network continues to seek solutions to barriers including access to care for rural and remote children, and workforce risks related to private and public funding structures and limited availability of funded specialist training positions.

36. At a local, LHD level, clinical innovations are assessed and prioritised via LHD governance structures, for example Clinical Streams, Clinical Councils and Facility and District services. In SWSLHD, the Director of Clinical Governance oversees formal clinical innovation programs, and the Director of Strategy and Partnerships is responsible for implementation of other ACI and innovation strategies.

(ii) Clinical innovation investment prioritisation

37. In SWSLHD, the prioritisation of clinical innovations is determined by reference to an assessment of a number of factors including service planning, health outcomes, patient experience, cost benefits or efficiencies, all of which can have short or long-term outcomes. The implementation and funding of geriatric outreach programs following evidence received by SWSLHD of impact on the admission of patients and improved outcomes for people residing in residential aged care facilities of a geriatric outreach program is one example.

38. SWSLHD's annual Service Level Agreement sets specific Key Performance Indicators (**KPIs**) to be achieved, including Hospital Admission Targets, re-admission rates, and hospital acquired complications. KPIs alone should not drive investment decisions, however, support for the introduction of new clinical innovations is often linked to measures that demonstrate ability to impact KPIs, as well as cost effectiveness benefits to offset any real budgetary impact of a new clinical innovation.

39. In my view, the ACI networks have driven positive change in LHDs regarding the use of PRMs to assess the effectiveness of a new clinical innovation. This focus on PRMs has influenced clinicians in how they set care goals and plan care with their patients. The linking of PRMs to specific Value Based Healthcare programs, including direct patient feedback on outcomes and experiences of care and the sharing and reporting of outcomes via the HOPE platform is supporting change. Further alignment of measures and inclusion of PRMs tools in the eMR will reduce patient and clinician reporting burden and help to guide care delivery and identify areas of low value care.

(iii) Funding of clinical innovations

40. As alluded to above, LHD budgets do not usually include funding to pilot clinical innovations without a business case, or unless there is a need identified to address an urgent problem or area of underperformance. As such, clinicians tend to explore opportunities that require formal submission for research or grant funding in order to fund the trial stage of a particular project. In my view, it is often difficult to obtain recurrent

funding for successful initiatives due to LHD ABF arrangements. This is also the case with identifying budget and FTE support to appropriately implement statewide models, such as the workforce requirements of Leading Better Value Care initiatives. An example of significant statewide investment that has supported new clinical innovation is palliative and end of life care, where enhancements were able to be designed to target local needs with innovations in community workforce models and capital investment, as well as identified priority areas such as Aboriginal Chronic Care Coordinators.

41. In my opinion, the funding of clinical innovations could be improved particularly at the trialling stage. I acknowledge the risk of project failure, although seed funding can increase the engagement of clinicians and consumers and help with implementation, scalability, and to refine care models, as well as develop innovative solutions. There are, however, obvious inefficiencies when multiple people across different LHDs compete and test the same thing. A level of centralised oversight, coordination and funding support can help efficient trialling of, and implementation of new clinical innovations. The ACI, the Ministry of Health and LHDs have done so very successfully at times, however, in many areas progress is slow. Some clinicians become frustrated and believe that ACI is ineffective as it can only influence or encourage change, as funding decision are ultimately with LHDs. Others believe that ACI provides clear direction on evidence-based models of care and any inaction is because the LHDs themselves are not engaged and obstructive. In my view, the constant focus must remain on ensuring stronger collaboration and positive culture with interactions between LHDs, the Ministry of Health and the Pillars, inclusive of clinician and consumer voices if we are to deliver on our commitment to safe, quality and efficient care.

D. THE ACI

(i) Dissemination of information regarding new models of care, technical innovations or clinical innovations developed in one LHD

42. The ACI Clinical Networks support clinician engagement across LHDs and the dissemination of information regarding new models of care. Specific networks provide education forums and links through communities of practice that increase visibility and sharing of innovations developed in one LHD. Other innovations visible to ACI are shared broadly on platforms or are referred to networks for review. The Clinical Redesign programs formally present project outcomes and share innovations across LHDs, and these are available through Redesign leads and web directories. More often than not, a new model of care or innovation will have some components already in place in other

jurisdictions and it is other factors including workforce models, system enablers, implementation science approaches and leadership that ensures the success and sustainability, or not, of a particular innovation.

43. In my view, the effectiveness of information sharing from ACI networks to LHDs often depends on personal relationships between clinicians, network members and relevant LHD staff and managers. If good relationships exist, then new models of care or innovations are effectively disseminated. When good relationships do not exist, or there are competing demands or priorities, then the effectiveness of that dissemination is reduced. I have experienced mixed messaging from the Ministry of Health and the ACI on new developments, and in my view the effective adoption of models of care requires a consistent system-wide message on a topic. I have also experienced LHDs become cynical regarding adoption of new models they self-assess as already having implemented, or rightly or wrongly, they believe their own local strategies and alternative innovations will result in better outcomes. In-reach rehabilitation teams in acute hospitals, the various models across LHDs supporting rapid post-acute discharge follow up and constant remodelling of frailty programs and hospital acquired functional decline models are specific examples of where a coordinated and simplified message may yield greater benefit.

(ii) ACI's role in reviewing and scaling new models of care, technical innovations or clinical innovations developed in one LHD

44. The ACI's role is to support the scaling up of new models of care, including considering whether a particular model of care or innovation should be standardised across the state. The ACI networks, communities of practice and clinicians work with the Ministry of Health and executive teams to prioritise innovations for scale up. The move to a value-based healthcare approach will aim to embed the principles for improving and adopting models of care rather than focusing on specific conditions such as Chronic Obstructive Pulmonary Disease, Congestive Heart Failure Osteoarthritis, or Diabetic High Risk Foot models for scale up.

45. ACI examples of new innovations or models of care are set out above, along with others in partnership with eHealth and LHDs. For example, the development of the osteoporotic fracture finding tool in the eMR, and the significant work undertaken through the surgical services taskforce and the emergency care institute.

46. The ACI also works with research groups and evaluation teams to support scaling of models and dissemination of evidence. This occurs in partnering with universities, academic networks, research institutes and clinician researchers on formal grant applications and other research activities, sponsorship and steering committee involvement, seed grants and other implementation activities. The ACI Musculoskeletal Network for example has supported multiple NHMRC and Medical Research Future Fund projects, policy development at state and national level, and the development of Australian Health Safety and Quality Commission Clinical Care Standards.

Matthew Jennings

Witness:

18/6/2024

Date

18.06.2024.

Date