Special Commission of Inquiry into Healthcare Funding

Statement of Jill Ludford

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Occupation:	Chief Executive, Murrumbidgee Local Health District

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.

A. INTRODUCTION

2. My name is Jill Ludford. I am the Chief Executive of the Murrumbidgee Local Health District (**MLHD**), a role I have held since August 2014.

3. In my role as Chief Executive, I lead a team of approximately 3,600 full time equivalent staff to deliver healthcare across MLHD, comprised of 4,995 total staff. I am responsible for providing safe, equitable and quality healthcare to the people of Murrumbidgee through strategic leadership and sound governance. A copy of my curriculum vitae is exhibited to this statement and marked '**A**'.

B. GOVERNANCE

4. The role and function of MLHD, including my role and that of the Board, is principally set out in the *Health Services Act 1997*. The relevant frameworks for MLHD's delivery of healthcare services are as follows:

    a) The NSW Health Performance Framework 2023;

    b) Future Health: Strategic Framework 2022 - 2032;

    c) NSW Regional Health Strategic Plan 2022 – 2032;

    d) NSW Aboriginal Health 2013 – 2023, a copy of which is exhibited to this statement and marked '**B**';

    e) Corporate Governance and Accountability Compendium for NSW Health;

    f) MLHD's Service Agreement with the Secretary, a copy of which is exhibited to this statement and marked '**C**';

    g) MLHD's Strategic Plan, 2021 to 2026, a copy of which is exhibited to this statement and marked '**D**'.

    h) MLHD Clinical Governance Framework 2023-2027, a copy of which is exhibited to this statement and marked '**E**';

    i) Model By-Laws 2021, a copy of which is exhibited to this statement and marked '**F**';

j) MLHD Board Governance Charter 2023, a copy of which is exhibited to this statement and marked '**G**';

k) MLHD Risk Management Framework, a copy of which is exhibited to this statement and marked '**H**';

l) MLHD Risk Appetite Framework, a copy of which is exhibited to this statement and marked '**I**'.

(i) MLHD Board

5. The current MLHD Board consists of eight members, who bring expertise from financial, healthcare, health management, and community perspectives. The MLHD Board has a mix of skills and experience in accordance with section 26 of the *Health Services Act* 1997 (NSW).

6. Sub-Board committees are Quality Patient Care and Safety, Audit and Risk, Planning Resources and Performance, Medical and Dental Appointments Advisory Committee, a joint board sub-committee with the Murrumbidgee Primary Health Network (**MPHN**), and a newly formed Aboriginal Health and Wellness Committee.

7. There are also two advisory committees consisting of the District Clinical Council and District Medical Staff Executive Council, which brings together clinicians from across the District to discuss strategic planning, priorities for service development, clinical policy development and to provide expert clinical guidance.

8. The purpose of the Aboriginal Health and Wellness Committee is to assist the District to carry out its responsibility to provide high quality culturally safe, and equitable healthcare, free of prejudice and inequity for Aboriginal people. The Committee monitors the implementation of strategies in this regard.

9. Consumers participate in the Quality Patient Care and Safety and Aboriginal Health and Wellness Sub-Committees. A health consumer is anyone who has used, currently uses, or will use health care services. It also includes their family and caregivers.

10. I am accountable to the MLHD Board for the management and control of the operations and performance of the District, in accordance with the relevant legislation, policies and procedures and with the District's Service Agreement.

(ii) Community engagement

11. Consistent with the NSW Regional Health Strategic Plan 2022 – 2032, a key priority for MLHD is community engagement. The Strengthening Local Health Committees across Regional NSW report, developed by the Regional Health Division of NSW Health, discusses community engagement through local health committees. The MLHD implements strategies in this regard. A copy of the MLHD Community Engagement Framework is exhibited to this statement and marked '**J**'.

12. MLHD has 33 Local Health Advisory Committees (**LHAC**s), with a primary function to provide community input to the MLHD service system planning, community education and an avenue for trust building and gauging community sentiment. A copy of the Murrumbidgee LHAC Terms of Reference is exhibited to this statement and marked '**K**'.

13. The MLHD engages with the community through the LHACs who work together with their local hospital and/or health service sites. Each LHAC comprises up to nine community representatives (inclusive of a staff representative) who discuss local issues, provide feedback on District-wide service planning and relay information to and from the wider community on health service activities. The LHACs, along with facility managers, are invited to participate twice yearly in a Community Forum. Issues from their communities can be escalated from the local LHAC to the MLHD Chief Executive and Board every month.

14. These committees are an important part of the MLHD governance structure and play a significant role in supporting the delivery of best practice healthcare. The clinicians and community representatives engaged on these committees bring varied experiences and insights to assist in improved understanding of health needs and to inform service planning and delivery.

15. Further, four MLHD LHAC Chairs, one drawn from each of the four geographical sectors within MLHD, are appointed to the MPHN Community Advisory Committee (**CAC**), which is informed by 33 LHACs from across the Murrumbidgee region. The CAC, with membership from the community, MPHN and the MLHD, provide advice to the MLHD and MPHN about population health planning.

16. The MLHD Board connection to the LHAC system is through:

    a) the MLHD Board receives a monthly consolidated report of LHAC activities and matters for escalation,

    b) the twice yearly community forums, which is co-sponsored with the MPHN, and

    c) annual visits, along with myself, to each of the LHD facilities/services that includes a forum with local LHAC members, the local Council, staff and GP Visiting Medical Officer appointed to MLHD. The visits result in the acquisition of feedback about local experiences, issues and opportunities.

(iii) Collaboration with other LHDs

17. As the Chief Executive of MLHD, I attend a monthly Senior Executive Forum, which brings together the Secretary and Chief Executives from across the state to consider health issues of system-wide interest.

18. In addition, I attend monthly Regional Health Committee meetings with the Ministry of Health executive team and other rural chief executives. The

Committee sets the strategic priorities for regional health; leads system performance; and informs responses to emerging regional health priorities.

C. MLHD – geography, population and services

(i) Geography and boundaries

19. The MLHD covers 125,243 square kilometres in the Riverina and Murray regions of southern NSW. This includes the Snowy Mountains in the east, the plains of Hillston in the northwest, and along the Victorian border.

20. MLHD covers the traditional lands of the Wiradjuri, Yorta Yorta, Baraba Baraba, Wemba Wemba Perrepa Perrepa, Nari Nari and Muthi Muthi peoples.

21. The MLHD geographical boundary aligns with the MPHN geographical boundary.

22. The District encompasses 21 local government areas across the Riverina Murray region.

(ii) Population

23. MLHD services a population of approximately 250,000 people. As of June 2022, 19.2% of the population is aged under 15 years, and 21.5% is aged 65 years or older. There are currently 346 aged care residents in MLHD facilities.

24. People with Aboriginal and Torres Strait Islander background make up approximately 5.9% of the MLHD population, compared to 3.4% of the NSW population. Nine per cent of the Aboriginal population is aged 65 years and older, compared to 23% of the non-Aboriginal population.

25. MLHD also has a culturally and linguistically diverse community, with 7.5% of the population being native speakers of other languages and 10.4% of the population born overseas.

26. Socio-Economic Indexes for Areas (SEIFA) ranks areas according to their relative socio-economic advantage and disadvantage using 2023 Census data. All MLLHD local government areas are considered more disadvantaged than the Australian average. Nine per cent of the MLHD population lives in areas of high socioeconomic disadvantage and many MLHD communities experience lower levels of education, health literacy and household income.

27. In comparison to state averages, MLHD has a significantly higher rate of hospitalisation for all causes and potentially preventable causes.

28. A high proportion of the population's health care needs are primary healthcare based. This is on the basis that 16.6% of adults are diagnosed with diabetes, 36% with high cholesterol, 31% with high blood pressure, and 24% of children are assessed as developmentally vulnerable in one or more domains in their first year of school. The population has a higher prevalence of many lifestyle-associated risk factors than the state average.

29. Overall, local health challenges are cancer, heart disease, chronic obstructive pulmonary disease, mental health, suicide, smoking, above healthy weight, alcohol consumption, injury from motor vehicle crashes and falls, chronic kidney disease and an ageing population.

30. The Modified Monash Model (**MMM**) defines whether a location is rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (**MM**) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote. MLHD facilities are located in large rural towns (MM3, areas within 15km road distance of a town with a population between 15,000 and 50,000) to remote communities (MM6) (see paragraph 40 below).

31. The population projection to 2041 shows increases to Wagga Wagga, Griffith, Temora, and Young. Wagga Wagga is the largest regional city in NSW with an urban population of over 67,000 residents. In the remaining local government areas, there is limited population growth or decline.

32. The other main change in population in MLHD is the increasing proportion and number of older people. The number of people in the MLHD population aged 65 years and older has increased by more than 1,000 people each year since the 2021 Census. There is a projected increase of 8,000 people aged 75 years and older from 2021 to 2031.

(iii) MLHD health services

33. MLHD provides various community and inpatient health services. These include:

    a) Acute Care services - Maternal/ Neonatal and Women's Health, Planned & Acute Medicine, Surgery, Emergency and Critical Care Medicine, Child, Youth and Family Health, Cancer services, Coronary Care, Renal services , Metabolic obesity service, and Stroke care;

    b) Sub-Acute Care - Inpatient and community-based rehabilitation services, Inpatient and community palliative care, and Aged care services;

    c) Aboriginal health services - Aboriginal maternal infant health service, Aunty Jean's program to support Aboriginal people with/or at risk of chronic illness, Building Strong Foundations for Aboriginal children and families, Otitis Media Screening, Eye checks, Palliative care, and Cancer Care support;

    d) Ambulatory and Community Care - Allied heath, Alcohol and other drug services, Breast Screen, Child and family health, Chronic disease management, Community Nursing, Dental and oral health service, Men's health services, Palliative care, Specialist Outpatient Clinics, and Voluntary assisted dying;

    e) Mental health - Inpatient and community mental health services;

    f) Public Health - Infectious disease management and public health, and Sexual health services, Violence, Abuse and Neglect services; and

g) Clinical Support Services - Imaging services, Pathology, Pharmacy, Patient Flow and Transport.

34. In the 2022/2023 financial year:

a) Approximately 154,000 people presented to our Emergency Departments (**ED**s);

b) Over 69,000 admitted episodes to MLHD hospitals (referable to 34,101 people);

c) Over 18,000 surgeries were performed;

d) Over 2,100 babies were born; and

e) Over 677,000 non-admitted patient services were provided.

(iv) Facilities

35. A map of MLHD facilities is exhibited to this statement and marked '**L**'. Mercy Health NSW Ltd is an affiliated health organisation that operates two hospitals, Mercy Care Centre Young and Mercy Health Service Albury, which are also identified on the map.

36. MLHD health services are comprised of:

a) 12 hospitals

i. a rural referral hospital – known as Wagga Wagga Base Hospital;

ii. a base hospital – Griffith Base Hospital;

iii. 10 other hospitals: Cootamundra, Corowa, Deniliquin, Finley, Leeton, Narrandera, Temora, Tumut, West Wyalong and Young;

b) 19 Multipurpose Services (MPSs) – Barham, Batlow-Adelong, Berrigan, Boorowa, Coolamon-Ganmain, Culcairn, Gundagai, Hay, Henty, Hillston, Holbrook, Jerilderie, Junee, Lake Cargelligo, Lockhart, Murrumburrah-Harden, Tocumwal, Tumbarumba, and Urana;

c) Mental Health admitted services- Acute Inpatient Mental Health Unit, Wagga Wagga, Sub-Acute (Recovery) Inpatient Unit, Wagga Wagga, and Older Person's Mental Health Unit, Wagga Wagga;

d) 6 Specialist Community Mental Health, Drug and Alcohol Services in Deniliquin, Griffith, Temora, Tumut, Wagga Wagga and Young;

e) 12 Community Health Centres, Cootamundra, Corowa, Deniliquin, Finley, Leeton, Narrandera, Temora, Tumut, West Wyalong, Wagga Wagga and Young;

f) Southwest Brain Injury Rehabilitation Service; and

g) BreastScreen NSW services in Wagga Wagga, Griffith and Albury.

37. All facilities have access to virtual care services.

38. There are 407 MLHD residential aged care beds across the region. Currently, there are 346 residents occupying these beds.

39. MLHD rural hospitals are arranged in organisational clusters, with larger acute hospitals supporting a number of MPS sites, as follows:

a) Narrandera/Leeton Cluster: Leeton Health Service, Narrandera Health Service, Hillston MPS, Lake Cargelligo MPS and Lockhart MPS;

b) Deniliquin/Finley Cluster: Deniliquin Health Service, Finley Health Service, Hay MPS, Barham MPS, Jerilderie MPS, Urana MPS;

c) Corowa Cluster: Corowa Health Service, Berrigan MPS, Tocumwal MPS, Henty MPS, Culcairn MPS, and Holbrook MPS;

d) Tumut Cluster: Tumut Health Service, Tumbarumba MPS, Batlow-Adelong MPS, and Gundagai MPS;

e) Temora Cluster: Temora Health Service, Cootamundra Health Service, Coolamon-Ganmain MPS, and Junee MPS; and

f) Young Cluster: Young Health Service, West Wyalong Hospital, Boorowa MPS, and Murrumburrah-Harden MPS.

40. The MM classifications of the MLHD facilities are:

MM Level	Locations
MM 3 **Large rural towns**: Areas within 15km road distance of a town with a population between 15,000 and 50,000.	Wagga Wagga, Griffith
MM 4 **Medium rural towns**: Areas within 10km road distance of a town with a population between 5,000 and 15,000.	Corowa, Cootamundra, Deniliquin, Narrandera, Leeton, Temora, Tumut, Young Hospital
MM 5 **Small rural towns**	Barham, Batlow, Berrigan, Boorowa, Coolamon, Culcairn, Finley, Gundagai, Harden, Henty, Holbrook, Jerilderie, Junee, Lockhart, Tocumwal, Tumbarumba, Urana, West Wyalong.
MM 6 **Remote communities**	Lake Cargelligo, Hay, Hillston.

41. While separate organisations to MLHD, I note Albury Mercy Care is located in a MM2 regional centre, and Young Mercy in a MM4 location.

Referral Hospital – Wagga Wagga Base Hospital and community services

42. Wagga Wagga Base Hospital (**WWBH**) is a 335-bed referral hospital. It supports approximately 46,380 emergency presentations, 13,770 operations and 1400 births each year. A redevelopment was completed in 2021 and delivered a new mental health inpatient unit, an acute service building and health service hub. A multi-storey car park was completed in June 2023.

43. WWBH provides services including critical care, medical, surgical, paediatric, obstetric, and rehabilitation care. It has acute aged care inpatient beds, rehabilitation inpatient beds, an older person's mental health unit, acute and sub-acute mental health units, rapid access clinic/hospital in the home, renal dialysis unit, oral (dental) service, and 60 clinic rooms and treatment spaces for allied health, outpatient, and community health services. Specialist teams include cardiovascular, respiratory, gastroenterology, renal medicine, obstetrics and gynaecology, radiology, orthopaedics, psychiatry and paediatrics.

44. Oncology services for the Wagga Wagga region are provided under a contract for services with a third party provider, Cancer Care Associates, at the Riverina Cancer Centre located within the grounds of the Calvary Riverina Hospital, a private hospital in Wagga Wagga. The District's multi-disciplinary cancer team, including breast and prostate nurses, support patients receiving care at the centre, and WWBH provides chemotherapy to admitted patients.

45. WWBH has clinical education and training spaces, including a simulation centre with 4 simulation laboratories and skills areas that facilitate virtual and group training; and a library. These spaces are all digitally enabled, supporting clinicians from across the District able to participate in education and training sessions through virtual means.

46. The District's Virtual Care Hub and Community Care Intake Service, located in the WWBH, provide services District wide. The District's Virtual Care Hub is staffed by onsite nurses and virtual doctors who provide remote medical services, virtual critical care and retrieval for rural EDs, and virtual nurse assistance to early career nurses. The Virtual Care Hub also coordinates patient flow, including ambulance bookings, transfers to tertiary services, and operates a non-emergency patient transport service to maximise NSW ambulance availability for urgency care.

47. When there is no on-site General Practitioner (**GP**) medical coverage for a rural hospital, patients are managed through the Remote Medical Consultation Service (**RMCS**), available 24/7. This includes access to GP services for less urgent presentations, and virtual specialist teams who provide high level medical support. Appropriate patients can be admitted and managed in the rural hospitals using the RMCS. Whilst specialist doctors provide assessment, diagnosis, and

treatment via virtual care, patients requiring higher level care will be transferred to a Base Hospital.

48. A range of services are available to the Wagga Wagga community through the Wagga Wagga Community Care teams, via clinics, in-home support or virtual care. This includes community nursing, aged care support, child and family health, women’s health, diabetes service, cardiac and respiratory rehabilitation, palliative care, allied health and support services such as oral health, child protection and counselling, sexual health, and violence prevention and response services.

49. The Wagga Wagga Community Mental Health and Drug and Alcohol Service is a specialist service providing both inpatient and community assessment and support for people experiencing severe or complex mental health issues and/or drug and alcohol dependencies. The team includes nurses, social workers, occupational therapists, psychologists, psychiatrists, and consumer peer workers. Families and carers can access support from the family and carer support worker. The service works closely with local GPs, community organisations and other health and social services. Services are provided to people living in Wagga Wagga, and surrounding towns.

Base Hospital – Griffith Base Hospital and community services

50. Griffith Base Hospital is a 119-bed facility, with a 24-hour ED. It supports approximately 22,000 emergency presentations, 1,700 operations and 500 births each year. It provides a range of specialist services (both resident and visiting) including emergency medicine, critical care, general medicine, surgery, paediatric medicine, oncology, obstetrics, respiratory medicine, renal dialysis, Hospital in the Home and rehabilitation. Additional services include physiotherapy, dietetics, social work, pharmacy, occupational therapy and Aboriginal health. There are also a range of diagnostic services including pathology, CAT Scans, nuclear medicine, ultrasound and general x-ray. The population of the Griffith Council region is approximately 27,000.

51. Griffith Community Care Centre provides local community health services, including community and family health, allied health, palliative care, diabetes education and chronic care.

52. Griffith Community Mental Health and Drug and Alcohol Service is a specialist community service that includes assessment and support for people of all ages experiencing severe or complex mental health issues and/or drug and alcohol dependencies. It provides specialist mental health and drug and alcohol services to people living within the Griffith catchment (including Leeton, Narrandera, Barellan, Coleambally, Hillston and Lake Cargelligo). It is a similar multidisciplinary team mix to the Wagga Wagga Community Mental health and Drug and Alcohol Service.

53. The community mental health team work closely with local GPs, community organisations and other health and social services to provide services such as Well-ways After Suicide Support Program, Aftercare, MyStep to Mental

Wellbeing, Safe Haven, Suicide Prevention Outreach Teams, The Community Gatekeeper, Substance Use in Pregnancy and Parenting Service, SAFE START, Getting On Track In Time – Got It!, and the Dementia Behaviour Assessment and Management Service.

Acute district hospitals and their community services (10 Hospitals)

54. Cootamundra Health Service is a 30-bed hospital with 27 hospital beds, 3 maternity beds, allied health, and GP services, and 24-hour accident and emergency service. The Cootamundra Community Health Centre provides a range of services via in-home support or virtual care. The population of Cootamundra is 7,500.

55. Corowa Health Service is a 53-bed hospital with 18 inpatient care beds and 31 residential aged care (**RAC**) beds, and 24-hour accident and emergency service. It also includes a range of community health nursing and allied health services including physiotherapy, occupational therapy, nutrition and dietetics, speech pathology and drug and alcohol counselling. The population is just under 6,000.

56. The RAC beds are part of a group of State Government Residential Aged Care Facilities (**SGRACF**), where the NSW Government holds a licence with the Australian Government. NSW Health then funds aged care services in some LHDs.

57. Deniliquin Health Service is a 46-bed hospital with 26 acute beds, 8 day surgery beds, 4 maternity beds, 6 emergency beds and 2 treatment rooms, and 24-hour accident and emergency service. It provides a 9 chair renal unit and a separate 3 chair oncology service. It is also a hub site for surrounding smaller communities and provides a range of community, allied health and mental health/drug and alcohol outreach services through the Deniliquin Community Health Centre and Deniliquin Specialist Community Mental Health Drug and Alcohol Service. Surrounding areas serviced include Moama, Cummeragunja, Mathoura, Jerilderie, Hay, Barham, Moulamein, Tooleybuc, Tocumwal, Berrigan and Finley. The population of Deniliquin is just under 8,000 residents.

58. Finley Health Service is a 16-bed facility and 24-hour accident and emergency service. Services include allied health and community care. Finley Health Service is the Hub site for a cluster of rural facilities (Finley, Berrigan, Jerilderie and Tocumwal) and supports clinical services in the local area.

59. Finley Health Service is part of a place based integrated health model, bringing together primary care, hospital services, and 3 tiers of aged care. Finley Regional Care, a not for profit organisation, was established to represent the continual expansion of primary, aged and community care services (see further paragraph 96 below with respect to Finley Regional Care). Adjacent to the Finley Health Service is the Finley Medical Centre with GPs and allied health services catering for community requirements. The Finley population is approximately 2,000.

60. Leeton Health Service is a 66-bed hospital with 5 emergency beds, 19 acute beds, 4 maternity beds and 38 residential aged care beds, with 24-hour accident and emergency. Allied health and GP services are available. The RAC beds are part of the group of SGRACFs. The population is 12,000.

61. Narrandera Health Service is a 34-bed hospital, including 6 day surgery beds, and 24-hour accident and emergency service. It provides additional community services such as physiotherapy, occupational therapy, diabetes education, dietetics, speech pathology, Aged Care Assessment Team, community nurses, Transitional Aged Care Program, counselling, drug and alcohol, Aboriginal maternal/infant midwife, an Aboriginal health worker, and child and family health and mental health. The population is 6,100 residents.

62. Temora Health Service is a 28-bed facility, including 19 acute care and 5 maternity beds, with a 24-hour accident and emergency service. It provides general ward, surgical, obstetrics, pathology, and radiology services. Temora community health services include community nursing, domestic violence counselling, physiotherapy, mental health and transitional aged care. Additional services provided by visiting staff include speech pathology, dietetics, dental and occupational therapy. The population of Temora is over 6,000 residents.

63. Tumut Health Service is a 30-bed hospital (16 acute care, 4 medical, 4 day surgery, 4 maternity, 1 palliative care, and 1 paediatric care), with a 24-hour accident and emergency service. It provides a range of community health services including community nursing, allied health and mental health services. A redevelopment was completed in 2022, which includes a new co-located ambulance station and on-site accommodation. The population of Tumut is just over 6,500 residents.

64. Tumut Health Service has the capacity to support WWBH admissions to improve patient flow and current demands at Wagga Wagga.

65. West Wyalong Health Service is a 22-bed hospital facility, with a 24-hour accident and emergency service. It also provides pathology services and x-ray, as well as a number of community health services such as Aboriginal health, nutrition and dietetics, occupational therapy, mental health services, palliative care and physiotherapy services. Over 3,000 people reside in West Wyalong.

66. Young Health Service is a 32-bed facility with 21 acute beds, 5 maternity beds and 6 day surgery chairs, with a 24-hour accident and emergency service. It offers a full range of community health services such as community nursing, allied health and mental health services which are delivered by the local team who also provide outreach to surrounding communities. Mercy Care Young adjoins the facility and provides a 26-bed rehabilitation and palliative care service. The population of Young is 11,800.

Multipurpose services (19 facilities)

67. The residential aged care services provided by MPSs outlined in this section are funded in collaboration with the Commonwealth Government as set out under the Funding section of my statement.

68. Barham MPS is a 6-bed facility, with a 24-hour accident and emergency service and community health services. The Barham Hospital capital works project was completed in 2020. All residential aged care is provided through Murray Haven Homes, a 55 bed community-based provider which is co-located on the hospital campus. The District relinquished previously held aged care licenses to ensure ongoing viability of the community provider. The aged care facility also provides palliative and respite care. MLHD provides acute health services, emergency care and community health services. The population is approximately 1,500 residents.

69. Batlow-Adelong MPS is a 24-bed facility with 5 acute care beds and 19 residential aged care beds, and 24-hour accident and emergency service. Community health services are outreached from Tumut and include community nursing, child and family health, women's health, speech and occupational therapy, physiotherapy and mental health and drug and alcohol services. The population is approximately 1,000 residents.

70. Berrigan MPS is a 14-bed facility with 4 acute care beds and 10 residential aged care beds, and 24-hour accident and emergency service. It provides a range of services including emergency care, palliative care, respite care, community care and allied health services. The population is just under 1,000.

71. Boorowa MPS is an 18-bed facility with 5 acute care beds and 13 residential aged care beds, and a 24-hour accident and emergency service. The population is approximately 1,500 residents.

72. Coolamon-Ganmain MPS is a 14-bed facility with 2 acute care beds and 12 residential aged care beds, and 24-hour accident and emergency service. It offers community nursing and a range of visiting services including dietetics, women's health, occupational therapy, speech pathology, and mental health and drug and alcohol counselling. The population is approximately 2,200 residents.

73. Culcairn MPS is a 35-bed facility with 7 acute care beds and 28 residential aged care beds, and a 24-hour accident and emergency service. A range of visiting services are provided including women's health, podiatry, diabetes education, hearing and physiotherapy. A facility upgrade was completed in 2019. The population is approximately 1,500 residents

74. Gundagai MPS is a 30-bed facility with 12 acute care beds and 18 residential aged care beds, and 24-hour accident and emergency service. Community health services include community nursing, a range of visiting services including child and family immunisation, dietetics, mental health/drug and alcohol, speech pathology, women's health and a geriatrician who visits 2 or 3 times a year. The population is just under 2,000.

75. Hay Health Service is a 27-bed facility with 9 acute care beds and 19 residential aged care beds, and a 24-hour accident and emergency service. A range of primary health care services are also provided including community nursing, early childhood nursing, mental health services, palliative care, physiotherapy, speech therapy and nutrition. A redevelopment was completed in 2021. The service became an MPS in 2024. Residential aged care was previously state funded, without commonwealth contribution. The population of Hay is just under 2,500 residents.

76. Henty MPS is a 15-bed facility with 3 acute care beds and 12 residential aged care beds, and 24-hour accident and emergency service. The population is approximately 1,200 residents.

77. Hillston MPS is a15-bed facility with 5 acute care beds and 10 residential aged care beds, and 24-hour accident and emergency service. Services include allied health, oral health, and women's health. The population is approximately 1,200 residents.

78. Holbrook Health Service is a 26-bed facility, with 10 acute care and 16 residential aged care beds, and 24-hour accident and emergency service. Services include allied health, and community nursing are available for residents. The population is just under 2,000.

79. Jerilderie MPS is a 15-bed facility with 3 acute care beds and 12 residential aged care beds. It provides palliative care, respite care and a range of community care and allied health services, supported by virtual care and speciality services on referral. Medical services are provided by a local general practitioner. Service modifications to temporarily cease 24-hour accident and emergency services were made with this site in mid-2023 due to critical workforce shortages. The site continues to operate without an ED. The population is just over 1,000.

80. Junee MPS is a 38-bed facility with 8 acute care beds and 30 residential aged care beds, and a 24-hour accident and emergency service. Community health services include community nursing, child and family health, diabetes education and physiotherapy. There are also a number of visiting services including an asthma educator, dietetics, mental health/drug and alcohol, podiatry, women's health, speech pathology and occupational therapy. The population is just under 6,500 residents.

81. Lake Cargelligo MPS is a 22-bed facility with 6 acute care beds and 16 residential aged care beds, and 24-hour accident and emergency service. Allied health and community nursing are available. The population is just under 1,500 residents.

82. Lockhart MPS is a 20-bed facility with 5 acute care beds and 15 residential aged care beds, and a 24-hour accident and emergency service. Community health services include generalist community nursing, and child and family services with several visiting services including physiotherapy, speech pathology, radiography, Aged Care Assessment Team, and general counselling. Lockhart also provides community nursing services to The Rock. The population of Lockhart is just under 3,500.

83. Murrumburrah-Harden Health Service is a 33-bed facility with 13 acute care and 20 residential aged care beds, and a 24-hour accident and emergency service. Allied health and community nursing are also available. The facility was redeveloped in 2021. The population is just under 2,000 residents.

84. Tocumwal MPS is a 16-bed facility with 6 acute care beds and 10 residential aged care beds, and 24-hour accident and emergency service. The population of Tocumwal is just under 2,000 residents.

85. Tumbarumba MPS is a 42-bed facility with 5 acute care beds and 33 residential aged care beds, and 24-hour accident and emergency service. The Tumbarumba community health services include generalist community nursing, child and family health, physical activity groups, and a centre-based day care. There are several visiting services including a school dental service, dietitian, mental health/ drug and alcohol, radiography, physiotherapy, women's health, speech pathology and occupational therapy. A redevelopment was completed in 2020. The population of Tumbarumba is just under 3,500 residents.

86. Urana MPS is a 23-bed facility with 3 acute care beds and 19 residential aged care beds, and 24-hour accident and emergency service. The population of Urana is approximately 300 people.

Other Services

87. The Southwest Brain Injury Rehabilitation Service is a specialist rehabilitation service for people with acquired brain injuries, living in MLHD. It includes allied health assessments, therapy, education and case coordination for adults and children with an acquired brain injury. The service's main office is in Albury with an outreach office in Wagga Wagga. Clients in northeast Victoria may be considered depending on service availability. The service includes community outreach and a 4 day a week Transitional Living Unit program in Albury. The Albury Prosthetics and Orthotics Service is also based at this facility.

Capital works

88. Major capital works from the last few years include:

    a) Culcairn MPS – 2019. The project included increased residential aged care beds from 22 to 28, larger residential rooms with ensuites, dedicated inpatient spaces and enhanced community health facilities. Also included was improved staff facilities, including accommodation and larger reception area;

    b) Barham MPS – 2020. In partnership with a local residential aged care provider, Murray Haven Homes (MHH), 20 aged care beds were built as part of the MHH facility, an increase in aged care beds by 10. The acute hospital was rebuilt and the existing community services building was converted to staff accommodation. The new facility includes single inpatient rooms with ensuites, new ED, x-ray facilities, community health spaces, and improved ambulance access;

c) Tumbarumba MPS – 2020. The complete redevelopment of the Tumbarumba MPS included a new acute inpatient wing, a new residential aged care wing, expanded ED, new community health area, three new staff accommodation units and a new carpark and a landscaped cultural garden and mural which is being completed in collaboration with the local Aboriginal community;

d) Hay Health Service – 2021. This included a reconfiguration of beds to better accommodate increasing demand for residential aged care, three new purpose-built on-site staff accommodation units and a new emergency triage space. Confirmation of the MPS allocation of 19 beds residential aged care beds followed in 2023;

e) Wagga Wagga Base Hospital – 2021. The Wagga Wagga Base Hospital Redevelopment Stage 1 included construction of new 50-bed facility for acute and sub-acute mental health services and was delivered in 2013. This delivered 30 additional mental health beds (10 acute beds and 20 sub-acute beds) and has considerably improved regional capacity to respond to community needs.

   Stage 2: The new purpose built 7-storey Acute Services Building began offering services to patients in January 2016. This building includes the ED, operating theatre, women's and children's inpatient units, new intensive care and high dependency units, angiography suites, additional inpatient beds, medical imaging and a rooftop helipad.

   Stage 3: The construction of the Health Services Hub finished in 2021 and the facility provides sub-acute, ambulatory, community and primary health care services from a single site on the hospital campus. Stage 3 also included refurbishment of a building in Wagga Wagga's central business district for BreastScreen NSW, as well as additional car parking and landscaping on the Health Service campus;

f) Murrumburrah-Harden MPS – 2022. The new facility is a 33-bed purpose-built service that provides integrated health services, residential aged care and community health services. It also included the addition of three staff accommodation units; and

g) Tumut Health Service – 2022. The $50 million redevelopment was completed in late 2022. It includes new impatient wards, ED, chair based services, pathology laboratory, a new collated ambulance station, new on-site accommodation, and installation of almost 2,000 solar panels across four areas on campus.

89. Future developments are:

a) Griffith Base Hospital – a $250 million upgrade is progressing and scheduled for completion in 2025. All major health services at the Griffith Base Hospital will be housed under one roof, in the purpose-built three storey Clinical Services Building designed to support contemporary models of care. Other

works as part of the redevelopment include the Non Clinical Services Building, removal of disused hospital buildings, landscaping and car parking;

b) Finley Health Service – design stage. In November 2021 the NSW Government announced $25 million for Finley Health Service. The project team was appointed in late 2022 and has begun working with staff, clinicians and the community in the planning stage; and

c) Temora Health Service – design stage. An $80 million investment was announced in December 2021. The project team was also appointed in late 2022 and has similarly begun working with staff, clinicians and the community in the planning stage.

(v) MLHD's clinical networks and/or partnerships

90. MLHD's main clinical networks or partnerships include:

a) The Murrumbidgee Primary Health Network (**MPHN**) – the District works in collaboration with the MPHN on a range of projects including "Living Well, Your Way", a chronic disease outreach service in collaboration with MLHD. Other examples are "Enhancing Paediatrics in Primary Care" via a community paediatrician, and the Snowy Valleys Collaborative Care (also in partnership with the Rural Doctors Network). See further information below and in models of care;

b) Aboriginal Medical Services (**AMS**) - the District works in partnership with a number of Aboriginal Community Controlled Health Services. The District is a member of the Murrumbidgee Aboriginal Health Consortium (the Consortium), established in 2015 to improve the health and wellbeing of Aboriginal people living in the Murrumbidgee region, by coordinating and implementing targeted strategies and initiatives through key regional stakeholders. Members of the Consortium include the Riverina Aboriginal Medical and Dental Corporation, Griffith Aboriginal Medical Service, Viney Morgan Aboriginal Medical Service, Riverina Murray Regional Alliance, Leeton Local Aboriginal Land Council, MPHN, Marathon Health and MLHD.

The Consortium is focused on 4 priority areas: enhancing health literacy, increasing awareness of health services, strengthening service delivery and the responsiveness of service, and improving coordination and integration between service providers.

There is also a recently established Hay Aboriginal Medical Service (HAMS), which is an Aboriginal Community Controlled Health Service. It is a primary health care service initiated by the local Aboriginal community in partnership with the Griffith Aboriginal Medical Service to deliver holistic, comprehensive, and culturally appropriate health care to the community;

c) Riverina Murray Regional Alliance (**RMRA**) - the Riverina Murray Regional Alliance has been established to represent the interests of community members and Aboriginal organisations in ten communities in the Riverina

Murray region. The Alliance covers Albury, Cootamundra, Cummeragunja, Deniliquin, Griffith, Hay, Leeton, Narrandera, Tumut and Wagga Wagga.

On 19 August 2020, an overarching Local Decision Making Ngunggiyalali (Accord) was signed between the NSW Government and the Riverina Murray Regional Alliance to commit to culturally informed service delivery for Aboriginal communities across the region. The RMRA delegates and government nominees report on the implementation of the schedules which cover Health, Healing & Wellbeing, Strengthening Families and Housing, and Law and Justice. Local Decision Making recognises the right to self-determination and the right to participate in decision-making and exercise full authority and self-management;

d) **St Vincent's Hospital** in Sydney – the District has a partnership with St Vincent's Hospital Sydney in relation to a range of clinical services, and clinical support. The services include addiction medicine clinics, rehabilitation service, cardiology service, haematology service, diabetes outreach health service, substance use in pregnancy and parenting clinic, and WWBH pacemaker clinic partnership;

e) Nepean Blue Mountains Local Health District – **Pain Service**. The Nepean Hospital LHD and Nepean Hospital Pain Clinic, MLHD and MPHN supports the development and effective operation of outreach pain management education and services. The outreach support includes Telehealth, multi-disciplinary support, and outreach site visits to provide clinical service delivery for clients and training and education for MLHD and primary care clinicians to build local capacity;

f) South Eastern Sydney Local Health District – **Telestroke;** Wagga Wagga, Griffith and Deniliquin are part of the NSW Telestroke Service, which offers people living in rural areas increased access to life-saving stroke diagnosis and treatment. The NSW Telestroke Service consists of a single virtual service 'hosted' by a facility and serviced by a roster of specialist stroke physicians. The NSW Telestroke Service connects local emergency doctors to specialist stroke physicians via a telehealth consultation. Determining a patient's stroke type and treatment options quickly is crucial and can be difficult outside of metropolitan areas. Telestroke removes these geographical barriers and improves outcomes for rural stroke patients, giving them a greater chance of surviving and leading a normal life;

g) **Nephrology Services**: Royal Prince Alfred clinicians at Sydney Local Health District provide the Griffith region with nephrology support for their renal unit and patients, including virtual case conferencing and regular chronic kidney disease clinics. In addition, Royal Melbourne Hospital provides nephrology support for the Deniliquin renal unit and patients, including virtual case conferencing and regular chronic kidney disease clinics, and provides 24 hour support for renal patients and clinicians. In addition, the Sydney Dialysis Centre supports home haemodialysis patients across the Murrumbidgee region;

h) The **Teleburns** models of care - Concord Hospital Burns Unit partners with WWBH and Griffith Base Hospital to provide a service for treating burns patients using eHealth NSW's State-wide unified communications platform and high definition video cameras that connect burns patients with specialists at the Burns Unit. Burns care relies on accurate visual and physical assessment and high definition cameras to give clinicians confidence to assess, diagnose and treat patients remotely;

i) Western Sydney Local Health District – paediatric dental specialist outreach clinic;

j) Sydney Children's Hospital Network (**SCHN)** – a partnership with WWBH subspecialty clinics of cardiology, neurology, nephrology, cancer care, haematology, rheumatology and neurology; virtual paediatric endocrinology clinic; and EEGs are reported by a paediatric neurologist;

k) **Kids Guided Personalised Service** (KidsGPS) is a care coordination service with the SCHN, and coordinates care from multiple health teams for children with medical complexity. The service addresses vulnerability and reduced access to appropriate services. KidsGPS was localised to MLHD in 2017 and has achieved the following results: 40% reduction in ED admissions, 42% reduction in day-only admissions, and 50,000km of family travel prevented;

l) HealthDirect – a State Wide virtualKids Urgent Care Service;

m) Foresight Australian – provision of **public ophthalmology clinics**; The District has partnered with Gordon Eye Surgery and Foresight Australia, a non-government organisation, to establish public eye services through Griffith Base Hospital and St Vincent's Private Hospital Griffith. The service has streamlined referral and assessment processes to improve access and communication between providers and the consumer. An ophthalmic outreach program between Griffith Base Hospital, Gordon Eye Services, Foresight Australia and the Griffith Aboriginal Medical Service provides training, skills and equipment to Aboriginal Health staff to screen patients for eye conditions that require specialist follow up. Patients diagnosed with an eye condition are referred to the public eye clinic. Aboriginal Health Workers have been trained to provide eye screening. Approximately 8% of consumers with eye conditions identify as First Nations people;

n) Mercy Hospitals NSW Ltd, an **affiliated health organisation**, operates Mercy Health Albury and Mercy Care Centre Young. These services provide public patient services, including sub-acute care including rehabilitation after hospital admissions, palliative care services, and the evaluation and management of older people.

o) Albury Wodonga Health is a cross-border health service providing healthcare services for the Albury area in NSW, and is a separate organisation to MLHD. I note MLHD provides some healthcare services in Albury, such as BreastScreen, oral health, and the Southwest Brain Injury Rehabilitation Service, as set out above;

p) St Vincent's Private Hospital Griffith – **orthopaedics**. The District has an agreement with Griffith Base Hospital to provide planned orthopaedic surgery until the completion of the new Griffith Base Hospital in 2025.

q) Murrumbidgee Health and Knowledge Precinct (**MHKP**) – The MHKP is a collaborative which brings together public and private health partners, education, industry and our local communities to stimulate innovation and a thriving research community, grow a resilient workforce and create employment opportunities, and unify services that are accessible. The MHKP will move from establishment in 2025 to realising the full potential.

   A collaborative governance model has been proposed by the parties to enable effective decision making, and to ensure that strategic and operational areas are clearly defined. Partners who make up the Interim Board include education partners (University of NSW and Charles Sturt University), the MPHN, MLHD, and Local Government (Wagga Wagga City Council). An Alliance of health partners has been established with over 40 member representatives from a wide section of the region, to bring relevant issues and opportunities to the Alliance for consideration. Three working groups have been established to provide subject matter expertise to the following areas and guide initiatives and the way forward. These include: Education and Workforce, Research and Innovation, and One System Integration.

MPHN and MLHD

91. The MLHD has a close working relationship with the MPHN. In late 2022, a joint Board meeting was held to identify current challenges and future opportunities. Agreement was reached between both organisations to establish a formal Collaborative Agreement, which was signed in 2023 (**the Murrumbidgee Collaborative Agreement**). A copy is exhibited to this statement and marked '**M**'.

92. The partners acknowledge and commit to the principles and priorities of the NSW Joint statement between the NSW Primary Health Networks (**PHN**s), NSW Health and the Primary Care Division of the Australian Government, Department of Health. A copy is exhibited to this statement and marked '**N**'. The Joint Statement is a framework for NSW Health and PHN agreements, programs, projects and services at the regional and state level and facilitates how to work together on new initiatives.

93. The Murrumbidgee Collaboration Agreement sets out our local commitment to progressing state-wide and regional priorities. The partners acknowledge the importance of ensuring clarity of the high level roles and responsibilities that exist at a governance level and between organisations. MLHD and MPHN have identified three key focus areas that will guide our collaboration activity:

    a) Enhance collaboration to optimise use of the health workforce and support wellbeing of providers;
    b) Identify, review, and develop models of care that enhance coordination, efficiency, and patient experience;

c) Facilitate joint information, data sharing and planning to understand and improve the health and wellbeing of our communities.

94. The Murrumbidgee Collaborative Agreement formalises the existing partnership and strong commitment between both organisations to work towards a shared vision of *one health system for the Murrumbidgee*. A joint governance model has been agreed to ensure adequate governance and joint accountability at all levels, strategic, operational and project. These arrangements include a joint Board Sub-Committee, Patient Centred Commissioning Group and a joint executive collaboration group. The joint Board Sub-Committee aims to identify and agree on joint focus areas, monitor and review progress towards the priorities of the agreement, and actively monitor the health environment to identify new and emerging partnership opportunities.

D. MODELS OF CARE

95. The following are examples of models of care implemented at MLHD, in addition to those set out above, that have been successful in the delivery of health care at MLHD.

96. Multi-disciplinary **integrated community model**. MLHD is working on place based integrated models of care with primary health and aged care providers. The Finley Health Service is part of a community led integrated health model incorporating primary and community care, acute inpatient care, supported aged care home packages and residential aged care. The District works in collaboration with Finley Regional Care, a community managed not-for-profit organisation, and the Berrigan Council, to plan and deliver integrated services to the community. Services are co-located on a health campus, with Finley Regional Care providing primary and aged care services. The District has used a pooled funding model with the MPHN to purchase allied health services from a third party provider for the community. The funding model combined state, commonwealth and MBS billing opportunities to create a viable service.

97. **Virtual care services**: include community virtual hubs, virtual nurse assistants, Remote Medical Consultation Service and technology assisted access to specialist care/links with tertiary hospitals. At MLHD, 23 per cent of non-admitted services are delivered via Virtual Care.

98. The District Virtual Care Hub is staffed by virtual nurses and doctors who provide remote medical services, rural ED virtual critical care and retrieval, and virtual nurse assistance to early career nurses. The Virtual Care Hub also coordinates patient flow, including ambulance bookings, transfers to tertiary services, and operates a non-emergency patient transport service to maximise NSW ambulance availability for urgency care.

99. **Telestroke** – as set out above. The model also includes regular meetings to assess activity, clinical management and follow-up of stroke patients.

100. **Collaborative Commissioning** - Collaborative Commissioning is a new way of delivering care with partners, including the MPHN and third party providers, to identify care pathways and/or gaps in local care pathways, and develop, fund,

and co-manage approaches. MLHD has selected Chronic Obstructive Pulmonary Disease (**COPD**) and congestive heart failure (**CHF**) as Collaborative Commissioning focuses, reflecting health needs in the MLHD community. Programs developed as part of the Collaborative Commissioning initiative include outreach cardiologist diagnostic clinics, expansion of the Rapid Access Clinic, and winter strategies. Some of these programs are deployed using innovative models of care, such as home monitoring, involvement of pharmacies and virtual technology so that patients in remote areas can access these services.

101. Collaborative Commissioning has a joint governance committee, the Patient Centred Co-Commissioning Groups (**PCCGs**). There are a number of staff who report to this structure. The PCCG oversees several projects covering chronic disease, diabetes and a bilateral mental program, Head To Health. One chronic disease initiative is the "Living Well, Your Way" program. It involves initiatives to improve health outcomes of people living with COPD and CHF within the Murrumbidgee region. Initiatives include: service mapping to identify service gaps, access to timely and affordable echocardiograms for the diagnosis of heart failure; outpatient clinics for early diagnosis and treatment of COPD, strengthened links to primary care to reduce preventable ED presentations and hospital admissions; and Outreach Heart Failure Diagnostic Clinics to ensure high risk patients have timely access to screening and diagnostic assessment in rural communities, with a focus on Aboriginal people. These clinics are delivered in conjunction with local general practices. Patients receive specialist care closer to home and have access to diagnostics at no cost to the patient.

102. The **Emergency Department to Community** (**EDC**) program: a statewide integrated care initiative. The EDC provides tailored intensive care and management to consumers in the community in order to reduce presentations to the ED. It is available to eligible consumers under the age of seventy who have been identified as frequent ED presenters (10 or more presentations within 12 months) with complex chronic health and social care needs. The EDC program is currently being rolled out by geographic cluster within the MLHD. Suitable patients are identified by the EDC algorithm, which is built into the Patient Flow Portal. The EDC algorithm considers ED admission history from the last four years, existing chronic conditions, and several demographic and social determinants.

103. A multidisciplinary team is assigned to patients in the EDC program to assist with the health and social issues facing the patient. A care coordinator from an allied health or nursing background is assigned to the patient to work with them in the primary care setting. The patient is also linked with a local GP.

104. **Rapid access clinic at WWBH**: the Rapid Access Clinic (**RAC**) at WWBH provides an alternative to the ED for the assessment, treatment and coordination of specific low acuity presentations. Patients may be referred to RAC from the emergency department or health providers, including general practitioners and NSW Ambulance. These include patients who present with chronic illnesses needing medical assessment, minor medical problems, superficial burns, lacerations, and minor musculoskeletal and fall-related injuries. The clinic was expanded to a 7 day per-week service in January 2023. In response to the RAC,

the WWBH ED has experienced a reduced number of triage category 4 and 5 patients and improved treatment times. Thirty per cent of RAC presentations identify as Aboriginal or Torres Strait Islander people. The service has been approved by the Ministry of Health to become an Urgent Care Service with HealthDirect referrals.

105. **Mobile specialist services** to rural hospitals and MPS: the District provides a range of specialist services to rural hospitals. This includes mobile dental teams for consumers in residential aged care, rehabilitation through virtual specialists and local teams, Dementia Behaviour Management Advisory Services, visiting outreach geriatricians, allied health, and community paediatrics.

106. **Support to rural Emergency Departments:** nurses working in MLHD rural hospital EDs have access to a range of systems and technologies to support the delivery of safe care in accordance with evidence based care pathways. These include:

    a) Point of Care testing (**PoCT**) - every rural MLHD ED is equipped with PoCT mobile devices to analyse pathology samples, such as blood, to provide on-the-spot results at a patient's bedside. Samples are processed instantly, rather than transported to a laboratory for testing, delivering accurate results to inform clinical decision-making and improve patient care and outcomes. Samples are securely uploaded to the patient's electronic medical record for immediate access by clinicians. PoCT supports the diagnosis of conditions including: heart attacks, kidney damage, sepsis, and diabetes.

    b) Cardiac reperfusion - a model of care for patients with suspected acute coronary syndrome (conditions caused by reduced blood flow to the heart and includes heart attack). STEMI is a type of heart attack which is a time-critical, life-threatening, medical emergency. It is essential to rapidly diagnose STEMI and restore blood flow to the heart to reduce the risk of heart failure or death. This process is known as reperfusion. The MLHD has a nurse administered thrombolysis model in small hospitals that do not have 24 hour on-site medical cover. The ECG is transmitted to a cardiologist or emergency physician for interpretation. If a STEMI is confirmed and the patient meets specific criteria, protocol directed thrombolysis is administered by nurses to dissolve the blood clot and open the artery. If the patient has another diagnosis, advice on patient management is provided.

    c) Critical Care Advisory Service: the District Virtual Care Hub provides virtual critical care nurses and doctors who can coordinate clinical care resuscitation and retrieval for critically ill patients in small rural hospitals. The local clinicians are supported though virtual technology to assess, treat and transfer patients to higher levels of care. Specialist teams such as the trauma team, the newborn and paediatric emergency transport service, and the NSW retrieval team can support local clinicians until help arrives.

Challenges and Opportunities

107. The models of care implemented at MLHD need to be tailored to its specific circumstances. It is not possible to adopt a “one size fits all” approach. MLHD’s unique characteristics, including its demographics and geography, mean that models of care developed at state level or those implemented in other LHDs may not be appropriate or may require tailoring.

108. As explained above, MLHD has a higher ageing population compared to the general community. Ageing populations influence the health system in multiple ways. These include increased use of health services and hospitals by older age groups, whose health service requirements are more complex due to high levels of multi-morbidity. The demand on the regional EDs such as Wagga Wagga and Griffith is growing, impacted by the declining primary care opportunities with GPs, declining bulk-billing rates and availability of specialist doctors. Disability is also an important issue related to ageing which requires health system resources, in combination with other social support measures.

109. Future service models could be aligned to address the health needs of the community, strengthen the rural health workforce, and utilise the considerable health resources in a more sustainable way.

110. To address the healthcare disparities and to provide healthcare aligned to the health needs of the MLHD population, there is a benefit in shifting healthcare towards an integrated approach that combines hospital care with primary and secondary health services. There are a number of challenges to overcome for this to progress, including the lack of intra-operability between information technology (IT) systems, sharing of data and the requirement for agreed care pathways.

111. Moving to localised integrated service models creates a comprehensive healthcare system and a continuum of care, allowing for better management of chronic conditions, implementation of preventive measures, and early intervention. MLHD has taken steps to implement this through its formalised agreement, joint governance and partnership with the MPHN. The MHKP One System Working Party is also working on the development of a Regional Planning Framework that supports a one system approach to planning and prioritisation across the region.

E. PROCUREMENT

112. MLHD follows NSW Government and NSW Health policies and frameworks regarding procurement objectives and requirements.

113. MLHD has a Strategic Procurement Team, which sits under the Director of Finance and Performance. The team consists of eight staff members. MLHD developed a local Guideline to support the operationalism of the statewide policies and procedures. A copy of the MLHD Procurement Guide is exhibited to this statement and marked ‘**O**’.

114. MLHD obtains certain services from HealthShare NSW, eHealth NSW and NSW Health Pathology.

    a) HealthShare NSW – centralised procurement services, and provision of shared services including payroll and accounts, Enable NSW, food services, linen services, cleaning services, and warehousing. MLHD performs its own non-emergency patient transport, with some logistical software input from HealthShare NSW;

    b) eHealth NSW – centralised procurement services and provision of shared services, itself though a shared Chief Information Officer with Southern NSW LHD;

    c) NSW Health pathology – all pathology services, apart from specialist genetic testing. The District receives monthly reports on diagnostic pathology services that enables the MLHD to monitor changes in the volume of services provided month-to-month.

115. Like most other LHDs, we experienced supply chain disruption as a result of COVID. However apart from that, MLHD does not appear to experience any unique supply chain disruption. Freight and logistics pose a challenge due to distances for Sydney and are described below.

116. The District supports centralisation of contract negations using statewide volumes. Recent procurement reforms have led to improvements. These include:

    a) DeliverEASE - has improved inventory management at ward storeroom level as MLHD did not have any electronic system prior to the implementation of DeliverEASE. However, implementing DeliverEASE into ageing facilities requires significant capital investment, which was not included in the project. The District is unable to fund these upgrades and the project has been paused.

    b) The statewide Pharmacy Formulary has improved procurement with Whole of Health Pharmaceuticals and increased savings.

    c) Traceability has improved ordering processes on implantable items along with improved tracking with attached data to patients.

    d) The Master Catalogue System opens items not previously available to MLHD that may be on contract.

    e) Improved dashboards allow greater visibility to ordering patterns and identifying areas of improvement.

117. The District would like to see greater transparency around market testing that takes place by HealthShare. The current pricing model may not provide enough incentive to HealthShare to reduce the price. Currently the LHDs are responsible for the volume, with HealthShare setting the price. In addition, some Whole of Health contracts have the “best pricing” clause, this limits what negotiations the LHD can do with any supplier.

118. Establishing a Wagga Wagga Regional Distribution Centre (**RDC**) would be an opportunity to address the freight and logistic challenges caused by the distance from Sydney. It has been recognised by HealthShare that MLHD is in the “Bermuda Triangle” of delivery routes. Some direct purchases have minimum order quantities, especially on slow moving medical consumables that are used across the district. An RDC would allow MLHD to consolidate the volume of the district and stock these in the RDC. There are further logistics opportunities by combining consumable deliveries with linen from the Wagga Linen Service.

119. Improved pharmaceutical inventory management system would be an opportunity where the District could manage the purchasing, receipting of pharmaceuticals across the district, minimising over ordering and inventory loss due to product expiration.

F. FUNDING

120. The 2023 – 2024 Performance Agreement (Exhibit C) sets out MLHD’s budget for the period 1 July 2023 to 30 June 2024.

121. Wagga Wagga Base Hospital, Griffith Base Hospital, Deniliquin Health Service, Mercy Health Hospitals and inpatient mental health services at MLHD are activity-base funded. The balance of the facilities are block funded.

122. The current funding model acknowledges that the provision of regional health is more expensive with the inclusion of the Recognised Structural Cost Grant. The model includes a ‘keep safe’ factor with the inclusion of a Cost Price Adjustment (**CPA**) to support LHDs that have average costs higher than the State Efficient Price. The model includes a small hospital funding formula which is includes a fixed price and a variable price (based on NWAU) component.

123. NSW Health collaborates with the Australian Government in the development of the Multi-Purpose Service (MPS) program. MPSs providing health and aged care services in small rural and remote communities. MPSs receive funding through a flexible care subsidy from the Australian Government for aged care services, and NSW government funding for health services, capital and infrastructure costs. MPSs can use the combined funds flexibly to make use of resources and achieve the best outcomes. The MPS model can be effective when there is an insufficient catchment population to sustain a separate acute hospital, residential care, community health and home care services (generally from around 1,000 to 4,000 persons) or when there is an inability to access the mix of health and aged care services appropriate to the community needs due to isolation.

124. The NSW Health rural funding model does not include incentivisation or funding for health promotion/ prevention. The model is structured to be volume based and does not fund or incentivise improvement in health outcomes. There are some price adjusters, for example for non-admitted virtual care, however these are not material. In addition, the funding model uses costing information from the prior two years and as such does not recognise cost events that occur between the current year and the costing year.

125. Ultimately the budget model is limited by the existing budget of the MLHD. The CPA is limited with the use of the CPA Cap which reduces the overall CPA grant to the level of our budget.

126. The pricing system is based on state averages which uses, as its initial starting point, the State Average Price. This effectively means the model is the same for Westmead Hospital (160,000 NWAU) and Deniliquin Hospital (3,500 NWAU), and small rural sites have limited means for volume based productivity. The state average appears to be influenced by costs for the metropolitan LHDs and the larger regional facilities (John Hunter, Wollongong and Gosford). There is an opportunity to improve transparency on the small hospital funding model calculations.

127. There may be opportunities to look at the funding cycle and consideration of multiyear cycles. Funding is currently allocated on a yearly cycle, and this can bring uncertainty around funding allocation when funding allocations are adjusted in later years. This may be of benefit for transitioning to integrated service models.

128. There is also an opportunity for greater transparency about the funding allocated for new builds, and the application of the Financial Impact Statement.

G. WORKFORCE

129. MLHD has 3,600 full time equivalent staff to deliver healthcare across MLHD, comprised of 4,995 total staff. Healthcare staff are supported by hundreds of volunteers.

130. Expenditure on Visiting Medical Officers (VMO) at MLHD totals $58,699,472 and $61,901,843 for the financial years ending 2022 and 2023 respectively. The District's VMO payments this year are currently $7.9M higher than last year. Costs relative to last year are being impacted by additional deferred surgical activity and virtual GP support for the regional sites. The LHD has seen a significant increase in GP VMO costs at the regional sites relative to pre pandemic costs with GPs electing sessional rates (in accordance with the Rural Doctor's Settlement Package determination) to assist with balancing their time and increasing demands in their GP practices. These however also increase cost, but are more efficient than locum models. The use of the District's virtual Remote Medical Consultation Service is increasing with the declining GP numbers and more GPs electing not to work in hospitals.

(i) Challenges

131. The workforce shortage in rural areas across Australia is compounded by a maldistribution of experienced healthcare workers, with inadequate numbers choosing to work in rural areas. This imbalance not only hinders access to healthcare services, but also places undue pressure on the existing healthcare workforce. Sixty percent of MLHD's current nursing and midwifery workforce vacancies exist in small rural and remote regions.

132. Challenges of rural practice include professional isolation, distance from family, limited development opportunities and workloads.

133. Resolving this maldistribution and meeting the demand for healthcare workers in regionals areas will not be solved by increasing the supply of healthcare workers. It requires the implementation of new training pathways and workforce pipelines that equip health workers with the required skills and knowledge for working in regional areas and the recognition of the associated costs of premium labour.

134. Sites and services in MLHD are heavily reliant on premium labour to maintain service continuity, which significantly increases operational costs. For the last two financial years, MLHD expenditure on premium labour is as follows:

FYE	Agency nursing expenditure	Allied health expenditure	Locum medical expenditure
2022	$8,783,593	$135,655	$11,782,998
2023	$27,049,615	$164,134	$19,216,458

* Does not include additional costs associated with accommodation and travel

(ii) Opportunities

135. The recent implementation of financial incentives under NSW Health's Rural Health Workforce Incentive Scheme, aims to increase and stabilise the supply of health workers in rural areas while acknowledging the challenges of attracting and retaining a skilled workforce. The financial incentives are adjusted according the level of remoteness using the MMM. Separately to the Incentive Scheme, MLHD has taken out a large number of leases of residential properties and offers three months accommodation to people moving to the district.

136. Recruitment of staff is impacted by the lack of suitable accommodation across the District. The District has leased houses in rural towns when suitable accommodation becomes available. As of 30 January 2024, the District has 258 residences under lease agreements, providing 683 beds for staff accommodation. Local staff are then managing the allocation of this real estate portfolio.

137. In 2021, $45.3 million was announced by the NSW Government to deliver modern, accommodation for health workers close to health facilities in the Murrumbidgee, Southern NSW and Far West Local Health Districts. The District is working with Health Infrastructure on accommodation options for individuals and or families. New accommodation pods are being built in Leeton, Finley, Narrandera and West Wyalong. The District also has 182 beds in owned onsite accommodation, however much of this is not fit for purpose. Reviews have been undertaken of this existing staff accommodation, outlining existing dwellings requiring upgrades and sites suitable for units or houses.

138. Financial incentives are only part of the sustainable solution to address workforce shortages in rural areas. Addressing this problem comprehensively requires a holistic approach which also focus on developing team-based multi-disciplinary

models of care, providing career opportunities that allow health professionals to utilise their full scope of practice and creating a supportive and educational environment for healthcare workers to thrive. The goal is to create a workforce pipeline which identifies, trains and retains healthcare professionals specifically for rural settings.

139. Rural GPs, nurses and other rural health care workers require a broader skill and knowledge set than their counterparts in large regional cities and major metropolitan centres, because they see a much larger variety of patients and clinical problems. They also have limited locally available support services such as peers, specialists, radiology, and pathology. MLHD is working on developing end to end rural education and training pathways tailored to these unique challenges and needs of rural healthcare, including exposure to rural practice settings through clinical rotations. They promote rural generalism for nursing and allied health professionals as well as for rural generalist doctors delivering primary and hospital care in rural settings.

140. The Murrumbidgee **Growing Our Own Strategy** is aimed at streamlining education and training pathways and engaging people with a rural background to embark on a health career. It has enabled 134 new graduate nurses to commence in 2022 and 121 new graduate nurses to commence in 2023. In 2024, MLHD will be recruiting 147 new graduate nurse positions.

141. A nursing Grow Your Own initiative has commenced with a local university and TAFE to improve the student nurse experience, grow a rural generalist nursing workforce, strengthen the students' sense of belonging and familiarity and to grow highly competent rural generalist nurses. This Grow Your Own model is achieved through:

   a) Flexible study modalities – online and block sessions (the face to face traditional models excludes rural students with part time work, and families),

   b) Flexible clinical placement hours - the traditional model is full time and excludes rural students with local commitments,

   c) Clinical placements within MLHD (Base Hospitals, District and MPS sites) with accommodation support. In the traditional model students are sent anywhere across the state or interstate and have to pay travel and accommodation,

   d) Employment as an AIN upon completion of their first year of study to secure an income,

   e) Enrolled in undergraduate and postgraduate support programs, and

   f) Employment as a Registered Nurse upon successful completion of their studies.

142. In this model, students can study the Diploma of Nursing at TAFE NSW through the Albury, Cootamundra, Griffith or Wagga Wagga campuses or the Bachelor of Nursing through a local university, all while living within the MLHD footprint.

Successful students will complete all their clinical placements within the District to foster a sense of belonging and familiarity for the student. Students studying with TAFE will be supported with guaranteed clinical placements within the local area followed by direct employment opportunities upon course completion.

143. In 2024, MLHD is recruiting students studying registered nursing at a local university to the new end to end training nursing pathway, including 10 in their first year of study and an additional 10 candidates in their second year of study. Upon completion of their course, the rural generalist nurse will be provided with ongoing support for professional development including the opportunity to undertake post graduate studies and apply for available scholarships to consolidate their learning.

144. The **School Based Training Program (SBT),** a collaboration with Training Services NSW, attracts high school students in year 11 and 12. Students who are part of the program receive vocational training at TAFE, and concurrently work for MLHD. The students are paid for their work, and on completion of their training, they are guaranteed a job with MLHD. Students from this program are trained in areas such as assistants in nursing or allied health assistants. A high percentage of the students who are part of this program identify as First Nations people. The retention data for school-based trainees includes:

   a) 101 SBTs since 2020, including 55 First Nations students;

   b) 33 of the 36 students successfully graduated in 2023;

   c) 87% SBT's are employed by MLHD in qualified roles;

   d) 94% are employed in the health industry;

   e) 60% have accepted offers to university.

   f) 75% are progressing to further education (traineeships, university, or TAFE/vocational education and training courses).

145. **Flexible Rostering and Work Practices** in Nursing and Midwifery

MLHD is leading a pilot for nurses to undertake flexible rostering and work practices. The pilot aims to improve the retention rates within the profession. The project is currently in its initial phase of consultation and literature review to test possible options to be piloted. The project is being undertaken in collaboration with 2 other local health districts. The aim of the project is to develop a variety of flexible work options for nurses to test in the workplace.

146. **Virtual Nurse Assist** has been established to support early career nursing staff to work in rural hospitals while continuing professional development. These nurses may be the only registered nurse rostered in the facility on their shift, and an experienced virtual nurse is available 24 hours a day, seven days a week, to provide professional guidance. This is particularly relevant for ED skills such as triaging. Prior to this support program, early career nurses could not work in these small rural hospitals.

147. The Murrumbidgee **Single Employer Model** began as a pilot program in 2021 with the Australian government, in collaboration with the UNSW Regional Training Hub, to attract, train, retain and support rural generalist doctors. The pilot program provided 5 trainees per year over four years. It is the first of its kind in Australia. It is now being rolled out statewide. The program was designed to address a shortage of advanced skilled general practitioners (rural generalists) in regional NSW, making it easier and more attractive for junior doctors to train as rural generalists.

148. Employment arrangements for GP registrars present a barrier for potential junior doctors taking up rural generalist training. Traditionally, GP training consists of 6-month contracts which are privately negotiated between GP registrars and medical centres. GP trainees on these short-term contracts are unable to accrue leave and access other entitlements. Under the Single Employer Model, GPs have one employer (the local health district) for four years and have certainty about location, income and working conditions for the duration of their training program. They do not have to look for jobs independently, negotiate with hospitals about training programs, pay or rates, and are supported in their learning by the LHD. As NSW Health employees, they are entitled to sick leave, maternity leave and study leave. Their remuneration and award entitlements align with other medical specialty training, giving certainty and protection of the industrial award.

149. The Single Employer Model provides integration between hospital and community-based or primary care placements providing a wide range of experience, early exposure to rural GP placement and professional links with the region.

150. In order to address the GP shortage and pilot the program in MLHD, the Commonwealth granted an exemption under the *Health Insurance Act 1973* (Cth). In 2024, the NSW government was granted an exemption from the Commonwealth government to expand the pathway for up to a total of 80 rural generalist trainees per year in locations across regional NSW as part of the NSW Rural Generalist Single Employer Pathway.

151. The numbers of new GP trainees on the traditional training pathway has dropped from 23 in 2019 to just 7 in 2023. The District has had 25 GP trainees on the Murrumbidgee Rural Generalist training pathway since it commenced in 2021.

H. CONCLUSION

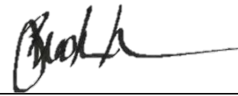
152. The information above highlights the evolving nature of healthcare, the changing demands of the health workforce, and the rising costs which are impacting the delivery of rural healthcare.

153. Because the health care system is complex, so are the solutions. Future healthcare models and services must be aligned to address the health needs of the community, strengthen the rural health workforce, and utilise the considerable health resources in a more sustainable way.

154. The MLHD has partnered with the MPHN, to determine localised priorities aligned with the population health needs. A formalised Collaborative Agreement and joint governance models are a strong start towards an integrated health system. In collaboration with the MHKP, a Joint Regional Planning framework and data sharing arrangements are progressing.

155. To tackle the broad opportunities and challenges facing rural communities, including urbanisation, demographic shifts, environmental change - we need to see them from a local perspective and work with local people and communities. Community engagement increases the visibility and understanding of issues and empowers communities to have their say over decisions that affect their lives, their towns, and their healthcare.

Jill Ludford



Witness: Brooke McCormack

12 March 2024

Date

12 March 2024

Date