Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Maryanne Hawthorn

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1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

A. My role

2. I am the Executive Director Strategic Reform, Planning and Partnerships for the Western New South Wales Local Health District (**WNSWLHD**), a role I have held since May 2023. From around May 2019, I was the Director of the Health Intelligence and Planning Unit of the WNSWLHD. My current role continues to include the constituent teams from my previous role, and additionally includes the strategic reform portfolio.

3. I report to the Chief Executive of the WNSWLHD, Mark Spittal. The following functions and teams form my portfolio:

   a. Planning – including strategic, speciality and clinical services planning, and change management for redevelopment projects,

   b. Health outcomes and evaluation – analysis of population health data, complex data analysis and evaluation,

   c. Strategic Reform, including the Strategic Project Management Office,

   d. Community Engagement,

   e. Data and information,

   f. Data integrity and clinical coding (virtual clinical coding unit), and

   g. Performance and analytics.

4. My role is to provide strategic leadership of these functions and teams at an executive level. This involves oversight of organisational strategy and health service planning; health intelligence, such as data analytics (including performance reporting and the use of data); data integrity and evaluation; engaging meaningfully with communities, and strategic reforms across the wider health system. The Directorate also supports some health intelligence functions for Far West LHD.

B. Planning and Service Development

5. These portfolio responsibilities include strategic, speciality and clinical services planning, and facilitating the annual planning process with the executive team and Board.

6. The Planning and Service Development team develops the WNSWLHD Strategic Plan and develops or supports other organisational or enabling plans.

7. The change managers for the facility redevelopments also sit within this team.

8. The current redevelopments in the WNSWLHD which this team is responsible for are as follows:

   a. Blayney Multipurpose Service (**MPS**): is the final MPS redevelopment to be funded from the current round of the NSW Government MPS Stage 5 program. It is at design phase with the outcome of construction tenders expected to be notified in the next month;

   b. Canowindra HealthOne: is an approximately $8 million development to create a HealthOne facility on the campus of Canowindra community hospital. The HealthOne will accommodate local GP services along with a range of community services provided by the LHD and some visiting services in one location in order to better support multidisciplinary primary and community care. It is at design phase, with demolition of several old buildings on the site underway;

   c. Cowra Health Service: this is a $110.2 million rebuild of the procedural hospital at Cowra to meet a range of community needs that have been identified through a local Clinical Service Planning process. It is at the early works / finalisation of the detailed design phase.

9. Due to the large size of the Bathurst Health Service redevelopment project, the Project Director reports directly to my position, but works very closely with the Bathurst Health Service, and collaborates with the Planning and Service Development team, and other teams within my Directorate as required.

10. The Bathurst Health Service redevelopment is a $200 million redevelopment of the hospital's emergency, inpatient, outpatient, mental health and support service infrastructure to meet a range of community needs that have been identified through a local Clinical Service Planning process. This project is at facility design stage.

11. WNSWLHD Clinical Service Plans (**CSP**s) consider how the health needs of a community can be met into the future. The CSP developed for our health services are extensive and will usually contain information about the unique health needs and challenges of the population in the area; what services can best meet these needs; future directions for the service; future infrastructure requirements and models of care. CSPs consider population needs, demographics and projections into the future, state and LHD strategic directions and plans, and emerging, evidence-based healthcare trends. WNSWLHD works closely with our clinicians, staff, community, local government and partner organisations to develop CSPs.

12. In general terms, my involvement is with the clinical services planning process, and the planning stages of a redevelopment, and is as follows:

   a. I will have high level oversight of the planning process (strategic or clinical services planning) and may be on the executive steering committee for the plan development. I chair the WNSWLHD planning governance committee. A CSP generally has a lifespan of about 10 years, however under certain conditions it may be updated sooner.

   b. To support infrastructure and capital investment processes, the CSP is to a facility level. However, WNSWLHD also develops some CSPs as a "network" of facilities to reflect the operation and networking of services in the LHD. For example, the CSPs for Dubbo, Narromine and Wellington are planned together as they work together in terms of service delivery.

c. Once the project receives a funding commitment, I will usually be involved in the governance committees with Health Infrastructure during the different stages for redevelopment, particularly during the planning and design phase.

13. More broadly, the Planning and Service Development team work alongside the Finance and Corporate team which sits outside my portfolio to develop and put forward the WNSWLHD Strategic Asset Management Plan and Capital Investment Proposals to the Ministry of Health through an annual process. The Planning and Service Development team supports the development of these capital investment proposals as they are mostly based on the CSPs.

C. Community engagement

14. In 2022, WNSWLHD commenced a new approach to community engagement under the Meaningful Engagement program, in response to the changing context for health care delivery, community demographics and expectations, and to create stronger community engagement and co-design.

15. Meaningful Engagement at WNSWLHD involves three levels of engagement:

a. Local or place-based engagement, which is tailored to meet the needs of the local community and health service. It may include (but is not limited to), committees such as a health council or group, or engagement with other existing health groups or networks or local emergency management committees. It includes local approaches to engaging with vulnerable groups, often led by local staff, including Aboriginal Health Workers. It may include local activities between the community and health service. A number of co-design projects have been initiated over 2023, for example the Ageing Well in Narromine project, or the vCare co-design project.

b. A sub-regional level, which brings a number of community representatives from towns within a region together. Two Sub-Regional Health Planning Committees have been established, with membership reflecting the diversity of communities within the region and with links to the Three Rivers and Murdi Parki Regional Assemblies. The two committees have been established to have a key role in co-design of solutions to challenges for health services into the future, and ways to improve the health of the community. While the committees are being formally evaluated in 2024, there is evidence of early success through strong participation and engagement by members, and the initiation of local projects in specific communities arising from the committee priorities.

c. Organisational level engagement, which involves building and maintaining trust with communities, and embedding strong community and consumer engagement through the work of the LHD. The WNSWLHD has facilitated this level of engagement by setting up the online platform called Engage, which enables community members to provide feedback in the planning and design of health services, and/or on other health projects. WNSWLHD also held its inaugural Community Conference alongside the Annual Public Meeting in October 2023. This and Engage Western provide the initial platform to build more organisational level engagement.

16. In addition to these formal community engagement mechanisms, community consultation may occur in relation to particular projects or work being undertaken by the LHD. For example, if WNSWLHD is undertaking a planning process, it will engage with the community for feedback. In addition to using the Engage platform or sub-regional committees (where relevant), it may also involve setting up consultation stands in

shopping centres, conducting surveys, community forums, meetings and workshops with community groups or organisations.

17. In my role, I also travel around WNSWLHD to meet community members, engage in consultation and chair the Sub-Regional Health Planning Committees.

D. Health Outcomes

18. The Health Outcomes portfolio is responsible for analysis of population health data for the Western NSW region, including development of the Western NSW Health of the Population Report (Health Needs Assessment) and local government area (LGA) health data analysis.

19. The team also undertakes complex data analysis, statistical analysis and evaluation. The team provides advice and support for staff across the organisation in program logic development, population health data, evaluation and research. This ranges from smaller scale initiatives to larger strategies, for example, development of program logic for the Allied Health Rural Graduate Program or evaluation of the WNSWLHD Improving Aboriginal Health Strategy.

E. Data and Information, Data Integrity and Performance and Value teams

20. The Data and Information team is responsible for the development of contemporary reporting solutions, data infrastructure and architecture and support the WNSWLHD Health Intelligence reporting platform.

21. The team will load, process, structure, summarise and present aggregated data in either interactive dashboard reports, static performance reports or ad-hoc analysis to support WNSWLHD operational leaders in the management, planning or evaluation of the health services they provide.

22. The Data Integrity team works with staff across the WNSWLHD to improve the quality and usability of their data, monitor data quality, fixes errors, and submits data to the Ministry of Health. High quality data is important for patient care, analytics, service planning and funding.

23. The Performance and Value team undertake detailed and ad-hoc analysis of facility performance and activity and respond to request for data to support operational management, planning, improvement or evaluation of health services in WNSWLHD. The team also includes the clinical costing team and clinical business partners who work with facilities to support performance optimisation.

24. The Virtual Clinical Coding team is responsible for coding of medical records across most WNSWLHD facilities.

F. Data to support planning between WNSWLHD and other agencies

25. As stated above, my Directorate completes the Health Needs Assessment. This is an assessment on behalf of the Western NSW PHN region, WNSWLHD, and FWLHD. Historically this was completed every 2 to 3 years, and now is updated more regularly as updated data on particular health outcomes becomes available. Western PHN, WNSWLHD and FWLHD all use this in planning work. The Health Needs Assessment is utilised by the WNSWLHD Executive, Board, and accessible to our LHD service leaders and managers. In addition, health priorities from the region emerging from the Health Needs Assessment are shared with local research networks.

26. There are multiple sources of data and information used in the Health Needs Assessment. These sources include data published by Commonwealth and NSW Government agencies, including the Australian Bureau of Statistics, NSW Department of Planning and Environment population projections, NSW Ministry of Health data such as Secure Analytics for Population Health Research and Intelligence (SAPHaRI), Notifiable Conditions Records for Epidemiology and Surveillance and Health Stats NSW, as well as the Australian Early Development Census and data from Hugo Centre for Population and Housing. While this provides a very comprehensive overview of the health of the population in Western NSW, there are challenges relating to data on health outcomes for Aboriginal people, small communities without data due to small counts, and the time lag for much of the data requires a longer-term view.

27. My Directorate also completes Local Government Area (LGA) profiles on population health data which are updated annually. These profiles utilise population health data from publicly available sources, analysed and presented in an accessible format to support planning by different agencies in the region. This information is used internally by WNSWLHD staff for planning or service development as well as other agencies such as the Primary Health Network, Rural Doctors Network (RDN) and Central West Joint Organisation (for local government). We also often participate in the Department of Regional NSW and Central West Joint Organisation State Government Planning for Councils Workshop, where this information can be utilised.

G. Strategic Reform team

28. The Strategic Reform team was established to develop a reform capability that positions WNSWLHD into the future to improve the delivery of health care to rural communities. While a dedicated team has been established, the function of strategic reform is supported by many roles within the Directorate. The strategic reform team is a proactive forward-looking team that can support development of reforms with external partners and broader system change.

29. The Project Management Office supports the alignment of projects to WNSWLHD's strategic plan, including involvement in implementation of priority projects and monitoring and reporting on performance and annual plan priorities. It provides support and advice, develops tools, and resources and provides education to staff to improve project management capability.

30. An example of a partnership is the collaborative commissioning project "Care Partnership – Diabetes". This project is a collaboration between WNSWLHD, Far West Local Health District, the Western New South Wales Primary Health Network and the Rural Doctors Network. The purpose of this project is to improve collaboration, consensus and capacity to achieve a more integrated health service landscape and improve patient outcomes for people with Type 2 Diabetes in the Western NSW region.

H. Challenges

(i) Health of the population and access to services

31. Residents of Western NSW (which comprises WNSWLHD and FWLHD) are one of the most isolated and most vulnerable populations in NSW. Life expectancy, risk factors and health outcomes are poorer than the average for the NSW population.

32. Across most Local Government Areas (LGAs) in WNSWLHD, access to primary health care and specialist care is at lower rates than the NSW average for WNSWLHD residents, despite a higher burden of disease.

33. Common issues raised through WNSWLHD community engagement mechanisms include the issues of transport to access more specialised services, including return home; access to general practitioners; health workforce recruitment, retention and sustainability ,and access to mental health and child and family health services.

(ii) Service demand, planning and planning in partnership

34. Changing demographics of the region have implications for service delivery and future planning in WNSWLHD. Increasing population in the larger regional centres and projected continued decline in some smaller communities will create challenges for the delivery of healthcare.

    a. Modelling should not be considered a foretelling of the future, however it does provide some indication of anticipated trends in activity and service demand. Base case projections modelled by WNSWLHD indicate that without any changes to models of care, emergency department (ED) activity will increase by 15% to 2036.

    b. Even with a small shifting of inpatient care to out-of-hospital settings (5%), acute inpatient activity (separations) will increase by 27% from 2020/21 to 2036. This projected growth equates to an additional 20,342 admissions or around 84 acute beds. These projections are nuanced between facilities, with the highest growth projected at the rural referral sites. MPS ED activity overall is projected to decline.

35. Enhancement and continued development of non-hospital alternatives to care will be necessary to meet future demand. Evolution of existing service models, including opportunities for integration of services, for example the MPS and HealthOne model in small communities, is also likely to better meet the needs of communities now, and into the future.

36. Joined-up, place-based planning is a shared goal across agencies in the Western NSW region. Collaboration and consultation occurs, however, there are often a number of discrete planning, reviews or analysis projects commissioned or undertaken which use similar sources of information or consult with similar stakeholders. It is difficult to establish a picture of the entire health eco-system for a community or a region; including all the service providers (visiting, virtual or physically located in a town).

(iii) Primary care and specialist care

37. Primary health care and general practice in many small communities is diminishing. The availability of timely and affordable access to primary health care has declined for many residents across Western NSW.

38. There is a direct interdependency between a general practice in a small rural town and the state-funded health services (typically an MPS). The strength of primary care across communities in the WNSWLHD has a significant impact on the health of communities, the workforce and the LHD's health services (emergency, acute and community services, mental health and residential aged care).

39. WNSWLHD internal analysis of Australian Institute of Health and Welfare (AIHW) Medical Benefits Scheme (MBS) data indicates that in 2023, people residing in 18 of 22 (82%) LGAs in Western NSW LHD had lower GP attendances per estimated residential population (ERP) than the NSW average.

40. WNSWLHD internal analysis of AIHW MBS data over that ten-year period (2013-2023) suggests that in 2023 the people who live in every LGA anywhere in the WNSWLHD catchment had lower rates of specialist attendance than the average across all of NSW. Analysis for publicly funded specialist outpatient services in the LHD's three rural referral centres (Bathurst, Dubbo and Orange) suggests there are several outpatient medical services where demand far exceeds capacity. Demand significantly outweighs capacity in paediatric services across the region, where children with behavioural issues can wait extended or infinite periods to access specialist care.

41. Comparatively lower access to both primary and specialist care impacts on health of communities, as well as the health care services provided by the WNSWLHD.

(iv) Infrastructure and redevelopments

42. WNSWLHD has a large infrastructure portfolio. Even though some hospitals may rank well in terms of physical performance, they may not rank well in terms of functional suitability and the ability to delivery contemporary models of health care.

43. There are several facilities in WNSWLHD that will require refurbishment or redevelopment to meet the needs of the population into the future, based on population demand drivers (acute and residential aged care) and infrastructure suitability. The future investment pathway for many of these facilities, particularly small community hospitals, is not clear.

I. Opportunities

44. There is an opportunity for prevention, an emphasis on minimising behavioural risk factors, and addressing the social determinants of health, to form a much stronger part of efforts to improve health for rural communities, and associated investment. This involves both Commonwealth and NSW Health agencies, as well as other Government agencies, including local government, over many years. Even with improvements to health services, without a focus on prevention and social determinants, health outcomes for people living in WNSWLHD will continue to lag.

45. 46. There is an opportunity for stronger State and Commonwealth planning on the framework for all health services that a population requires, from the core services for a community (such as primary care, community health, ambulatory care, aged care, palliative care, community nursing and community mental health and drug and alcohol services), as well as emergency care, obstetric, surgery, renal and chemotherapy services, to the highly specialised services available within the state network. Local and regional planning using this framework could then be nuanced to the health needs of the community, the population demographics and projections as well as the current services and gaps in this location, service development required and the funding mechanism to support this. There are opportunities for increased integration of services in small communities, which is underpinned by stronger and more accessible primary care. This may include further exploration and / or development of health precincts (in larger towns) or health places (in smaller towns). Evolution of the MPS and the HealthOne model in this direction could improve the sustainability of services in small communities, including stronger partnerships with the Aboriginal Community Controlled Health Organisation (ACCHO) sector.

46. A deliberate, strategic focus on increasing self-sufficiency of the Western NSW region would enable more specialised services, where appropriate, to be provided in locations closer to home for people living in WNSWLHD. There have been improvements in self-sufficiency over time in the WNSWLHD region (particularly in cancer services and cardiology). For example, medical and specialist outpatient services, linked to the health needs of the population, would be one priority.

47. Effective community and staff engagement and co-design is essential for any planning, service design or redesign.