Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Sally Pearce

Name: Sally Pearce

Occupation: Chair of Board, Far West Local Health District

1. This is an outline of the evidence I anticipate giving to the Special Commission of Inquiry into Healthcare Funding.

My role

2. I am the Chair of the Far West Local Health District (**FWLHD**, **the LHD**) Board. I have served on the Board since September 2019. I became the Acting Chair in June 2023 and was permanently appointed in January 2024. In addition to my role on the Board, I run my own consulting business and serve as a member of several Audit and Risk Committees within the NSW government. I am based in Sydney. A copy of my CV is at **Exhibit A (MOH.9999.1246.0001)**.

3. Section 12 of the FLWHD Board Charter (**Exhibit B (MOH.9999.1247.0001)**) sets out the role of the Chair of the Board.

4. The Board has four committees: Finance, Performance and Workforce; Safety and Quality; Aboriginal Health and Workforce; and Audit and Risk. It also has a joint committee with the Western NSW Primary Health Network. I am a member of the Finance, Performance and Workforce Committee, and the Aboriginal Health and Workforce Committee. I was also a Board representative attending the Audit and Risk Committee until June 2023.

Composition and function of the Board

5. The Board has eight members, four of whom currently live in Broken Hill. Each member brings specialist knowledge and expertise to support the Chief Executive and executive team. Board members can serve for a maximum total of 10 years. This enables sufficient stability in Board membership to provide continuity in the context of a rural and remote LHD that has seen change in executive staff.

6. The functions of the Board are as set out at s.28 of the *Health Services Act 1997* (NSW). These functions can be categorised within three broad areas.

7. Firstly, one of its critical tasks is to appoint and exercise employer functions for the Chief Executive for the LHD, in consultation with the Secretary NSW Health.

8. Secondly, the Board establishes the strategic direction of the LHD and ensures appropriate clinical, financial and corporate governance and risk management across the LHD. This includes achieving the obligations under the Service Agreement with the Ministry of Health and ensuring compliance with legislation and policy.

9. Finally, the Board facilitates, supports and encourages community and clinician input and participation in the development of the LHD's plans, strategies and operations.

10. The NSW Health Model By-Laws apply to the Board.

Committees

11. The Board also discharges its role through its committees. The **Finance, Performance, and Workforce Committee's** role is set out in the Terms of Reference (**Exhibit C (MOH.9999.1248.0001)**), and its primary purpose is to support and monitor the appropriate and efficient management of the operating and capital funds provided by the Ministry of Health. The Committee also plays a key role in monitoring performance against the Service Agreement and addressing workforce strategies and risks for FWLHD.

12. An example of an issue this Committee has considered is the management of excess annual leave across the LHD. Excess annual leave increased notably during the period of COVID. The Committee was concerned about the negative impact on staff wellbeing from not taking regular annual leave. Over the past two years, the Committee monitored the proportion of staff with excess annual leave from a peak of 43.4% in December 2022 to 32.7% in March 2024, below the pre-COVID March 2019 level.

13. The purpose of the **Aboriginal Health and Workforce Committee** is to oversee and guide strength-based strategies and programs to improve the quality, safety and cultural responsiveness of health services provided to Aboriginal people across FWLHD, and to monitor Aboriginal workforce strategies. The Committee ensures appropriate engagement across FWLHD with the Aboriginal community, partners and stakeholders. A copy of the Committee's Terms of Reference are at **Exhibit D (MOH.9999.1249.0001)**.

14. This Committee was re-established in December 2023. It covers both the health of our Aboriginal community and our Aboriginal workforce as improvements in these areas are interrelated. The provision of culturally safe care can only be achieved when the LHD reflects the community it serves. Aboriginal people were over 13% of the LHD's population in the most recent census but only 8.2% of our workforce. While 8.2% is the highest in NSW, increasing Aboriginal recruitment remains a priority.

15. The Committee is currently overseeing the development of the LHD's second Reconciliation Action Plan and reviewing available performance data to identify priority areas for action and monitoring. The Committee has examined the mix of Aboriginal staff across the organisation considering designated and non-designated positions, salary grades, and professional groups, to establish a baseline for measuring progress and ensuring our Aboriginal staff are represented across the organisation and across all salary bands.

16. If the Board is concerned about the LHD's performance, for example, if it is not meeting some of its KPIs, the Board or a Committee may question the executive team on that issue and ask it to undertake an in depth review or it may ask that more detailed information is provided on a periodic basis. For instance, a detailed report on Aboriginal patients discharged against medical advice is provided quarterly to the Board and, since December 2023, also to the Aboriginal Health and Workforce Committee, as continuously meeting this important KPI remains a challenge.

Community engagement

17. The Board has several mechanisms by which it engages with local communities within the LHD.

18. Each Board meeting starts with a written patient story, where a patient is able to describe their experience of our services and the emotional impact of the way our services are delivered. These stories centre our meetings by focusing on the importance of patient

centred care and the impact when that does not occur. Most stories include positive feedback and areas where improvement is needed.

19. FWLHD has a Health Council for each facility in the LHD and a Youth Health Council. A Health Council is comprised of local community members. Each Board member is assigned to a Health Council and will attend each of the meetings held by that Council. These meetings are held on a monthly or bi-monthly basis. The meetings consider reports from the local facilities, services provided, presentations on new or changing services, and obtain feedback on the activities of the facilities. I have been assigned to the Two Rivers Health Council, gaining direct feedback from Council members. The Two Rivers Health Council also provides considerable input into the current redevelopment of Wentworth Hospital. Feedback on specific issues is then shared at Board meetings.

20. The Board has recently implemented a system of touring the facilities within the LHD. Over the course of an 18-month cycle, each facility will be visited by Board members and the Chief Executive. Not every Board member will attend each site visit. This model replaces holding Board meetings at our facilities on a quarterly basis. The new arrangements should provide more time to meet with community members and staff and engage more meaningfully.

21. The Director of Aboriginal Health and Community Engagement provides a quarterly report to the Board on community engagement undertaken across the LHD. The Board and the Safety and Quality Committee also receive patient satisfaction survey reports periodically.

22. The Board also consults periodically with other organisations, as set out below.

Relationship with other organisations

23. The FWLHD is a core element of a network of healthcare providers across our communities. The LHD and the Board maintain relationships with other local health providers, such as the Royal Flying Doctor Service (**RFDS**), Maari Ma Health and Coomaella Health Aboriginal Corporation, aged care providers, and local General Practitioners (**GP**) in Broken Hill, Wentworth and Balranald, to ensure the efficient delivery of services across the LHD. The focus of the Board is ensuring services are provided by the most appropriate organisation and duplication of services is minimised. The FWLHD is essentially the provider of last resort across our communities if there are gaps in primary or aged care services. Where gaps exist, patients are more likely to require LHD services, through Emergency Department (**ED**) admissions, inpatient or outpatient services due to chronic disease or from an inability to discharge patients to aged care. These are strong incentives on FWLHD to work cooperatively with the network of providers across the LHD to minimise such avoidable presentations and enable our communities to receive care appropriately.

24. The Board engages with the two Aboriginal health providers in the LHD, Maari Ma Health and Coomaella Health Aboriginal Corporation. The Boards of FWLHD and Maari Ma Health recently had a joint dinner to restart direct contact that was limited during COVID-19. The Boards are planning to meet periodically to discuss opportunities for joint initiatives, including both service delivery and staff recruitment and training. The organisations have worked together with TAFE NSW to successfully enable Aboriginal Health Practitioner training to occur in Broken Hill, making the course more accessible and attractive to the local community.

25. The FWLHD recently established a joint committee with the Western NSW Primary Health Network (PHN), which meets quarterly. That committee comprises

representatives of each Board and the Chief Executives. The first meeting was held in February 2024, and a work plan is currently under development.

26. The FWLHD borders three states, with critical relationships with South Australia and Victoria who provide the main referral hospitals for the LHD.

27. Mildura Base Hospital provides emergency services and is a referral hospital for the Wentworth, Dareton and Buronga communities. The FWLHD and Mildura Base Hospital Boards and executives recently held an initial meeting to discuss shared opportunities, particularly in clinical service delivery with the construction of the new Wentworth Hospital and joint training and development opportunities for staff.

28. The Royal Adelaide Hospital is the main referral hospital for Broken Hill and the FWLHD has strong operational links with their services to facilitate the transfer of emergency and acute patients requiring tertiary services and to ensure continuity of care. NSW Health takes the leadership role in any strategic issues between the NSW and South Australian health departments.

29. One of the challenges in working collectively with other health providers is the difficulty in sharing patient records. As an example, a Wilcannia resident may receive treatment from Maari Ma Health, an RFDS GP clinic, and Wilcannia Health Service via an emergency presentation for the same condition. There is no automated process for sharing clinical records between the three organisations electronically. There is also no automated process for notifying the FWLHD that patients transferred to Royal Adelaide Hospital have been discharged home. Both of these examples involve complex IT and privacy issues. Each organisation has manual processes in place to share information but they are not ideal.

Challenges of rural and remote health services - workforce

30. The FWLHD is the most remote health service in NSW, providing services to a community of 30,000 people across eight locations. The key risk for FWLHD is attracting and retaining an appropriate workforce. The NSW Government Rural Health Workforce Incentive Scheme has assisted FWLHD in remaining competitive in recruiting staff in comparison to regional health districts, but the challenges in recruiting permanent staff remain. It is particularly difficult to recruit specialised nursing and allied health staff.

31. The additional contract cost of engaging agency nursing and locum medical staff impacts the District's financial performance. More importantly, the higher turnover in these staff requires extra focus to ensure staff are working within FWLHD and NSW Health policies, processes and models of care and have undertaken mandatory training.

32. Over recent years, technological improvements have enabled FWLHD to recruit specialised corporate staff that are based outside the LHD. This has increased the availability of skilled staff, but also involves additional travel and accommodation costs as most remote staff spend one week a month in the LHD.

33. FWLHD is regularly funded for a proportionate share of additional FTEs for new or enhanced state-wide initiatives. Given its small relative size, this can result in fractional FTEs being allocated to FWLHD, which are often not possible to recruit. In addition, new programs are often only funded for one or two years. It can take twelve months or longer to recruit some specialist staff, and there is little incentive for clinicians to move to Broken Hill for a one-year role.

Challenges of rural and remote health services – primary and aged care

34. According to the District of Workforce Shortage classification, FWLHD is operating in an area of need for GP and specialist services[1]. The RFDS is Commonwealth funded to provide GP clinics across most of the LHD (geographically). The joint committee of the Board and the Western NSW PHN has been established to work together to identify, resolve and advocate for primary care services across the LHD and to support better integration of primary and acute care (for example, by improving referral pathways).

35. Aged care services are a particular concern for FWLHD. The LHD provides aged care services at Wilcannia and Balranald Multipurpose Services. There are a number of private providers in the Buronga, Wentworth and Mildura region. There is one aged care provider, Southern Cross Care, providing services in Broken Hill.

36. There is currently a shortage of aged care beds available in Broken Hill. The single aged care provider is unable to provide services in line with community need, which is having a profound impact on Broken Hill Health Service. The number of patients awaiting transfer to aged care facilities is placing pressure on the LHD's ability to provide acute hospital services.

The effectiveness and limitations of NSW Health networks that link regional and remote facilities/LHDs with metropolitan tertiary facilities/LHDs

37. FWLHD has a range of relationships with metropolitan LHDs to provide services and staff. Partnering with another facility or LHD has benefits for patients and staff by providing continuing services and enabling access to high levels of clinical expertise and specialisation.

38. Below are examples of the arrangements that are in place. Some are statewide initiatives, and others have been established directly between the LHDs. NSW Health funds statewide initiatives, while local arrangements are undertaken on a cost-recovery basis. No single funding model exists for arrangements between LHDs. Models of care, staffing, technology, and infrastructure are collectively developed, with funding and contractual agreements then established to reflect these elements. The continuation of many services depends on the goodwill of the LHD providing them. There is no specific requirement for LHDs to provide these services, and the benefits to the providing LHD are often not measurable in financial terms.

39. Royal Prince Alfred Hospital (**RPAH**) within Sydney LHD provides a range of virtual services that support FWLHD and improve the quality and safety of our services. The virtual ICU and virtual ED services connect the FWLHD patients and clinicians with RPAH clinical teams to provide support for complex patients. The virtual ICU and ED services can also engage with the RFDS and Royal Adelaide Hospital for patients requiring transfer to tertiary hospitals. These services have significantly improved clinical safety by providing specialist advice that would otherwise not be available within the Broken Hill Health Service.

40. RPAH also provides a nurse assistance line, which provides 24 hour, seven day senior nursing support to staff across the LHD. Access to this service has reduced clinical risk,

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[1] Australian Government, Department of Health and Aged Care, Districts of Workforce Shortage accessed 30 April 2024: https://www.health.gov.au/topics/rural-health-workforce/classifications/dws [2] Aboriginal Health Framework 2021, FWLHD, accessed 2 May 2024 https://www.nsw.gov.au/sites/default/files/2022-03/farwest-aboriginal-health-framework-2021.pdf

particularly after hours in smaller facilities by ensuring nursing staff always have access to high level support and advice. It also reduces risks to staff wellbeing, as staff know they have support available when treating patients with complex clinical needs.

41. RPAH provide a senior registered nurse to work on a rotational basis in Broken Hill Health Service Emergency Department. This provides opportunities for sharing skills and techniques and strengthens the nursing skill mix within the ED.

42. Royal North Shore Hospital (**RNSH**) provides endocrinology services to Broken Hill Health Service through outpatient monthly clinics undertaken virtually and in person, with senior and junior medical staff under a cost recovery contract. This provides a continuity of service provision and models of care from clinicians with a long-term interest in the community and their patients.

43. Since 2023, RNSH has also been funded to provide support for menopause services under a statewide hub-and-spoke model funded by NSW Health. The NSW Health funding and support from RNSH have enabled a menopause service to be established, and provided expert advice both on the establishment of the service and in the treatment of patients with complex needs.

44. These arrangements are successful because they add to the services available to the local communities without diminishing the staffing levels provided locally for patients. The introduction of the virtual ICU and virtual ED, for instance, has not reduced the medical or nursing staff present in FWLHD. Instead, it provides additional specialist support to ensure the patients receive appropriate and timely care. The services are also successful because they are a partnership, with clear benefits to both FWLHD and the LHD providing the services.

45. The opportunity for FWLHD clinicians, at all stages of their careers, to be supported by models such as the virtual ED and RPA nurse assist programs is seen as a benefit in recruiting, developing and retaining staff. The impact on recruitment and retention will need to be measured over coming years.

46. Western NSW LHD provides a range of corporate and clinical services to FWLHD, including but not limited to ICT services, risk management, work health and safety, public health, and population health. These services are reimbursed under a fixed fee arrangement.

Providing health care to the Aboriginal people of the Far West

47. Improving the health of Aboriginal people within the FWLHD is a core responsibility and strategic priority. More than one in ten members of our communities are Aboriginal, and over 8% of our employees are Aboriginal. Lifting Aboriginal health outcomes and the quality, accessibility and appropriateness of our care is essential across all aspects of the LHD.

48. The FWLHD seeks to build strong partnerships with Aboriginal people, communities, and Aboriginal community-controlled health services, consistent with the Aboriginal Health Framework[2], to ensure the LHD is providing care that meets Aboriginal people's needs.

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[2] Aboriginal Health Framework 2021, FWLHD, accessed 2 May 2024 https://www.nsw.gov.au/sites/default/files/2022-03/farwest-aboriginal-health-framework-2021.pdf

The LHDis working to improve the cultural safety of our services, ensuring Aboriginal people are able to access the care they need.

49. Improving the appropriateness, quality and outcomes of health care for Aboriginal people is one of the most complex issues the LHD faces, and there remains much to be done. During my time on the Board there have been a number of steps made towards this goal. In July 2022, the Buronga HealthOne facility opened. It is the first NSW Health facility built on land owned by Aboriginal people. A landmark, long-term lease agreement was signed between the Barkandji Nations and the NSW Government that ensured native title to the site was preserved.

50. The LHD elevated the position of Director, Aboriginal Health and Community Relations to an Executive level in 2023, demonstrating the importance of this role across all aspects of the organisation.

51. The LHD developed and implemented its first Aboriginal Reconciliation Plan (2020-2022), strengthening community engagement and consultation. The second plan is currently under development.

52. The LHD is investigating expanding dialysis services to Wilcannia Health Service, removing the need to travel to Broken Hill (200km) to receive services.

Involvement in redevelopments

53. FWLHD has two major redevelopments underway: the construction of a new Wentworth Hospital, and the new Mental Health and Emergency Department at Broken Hill Health Service. Both projects will significantly improve the experience of patients and staff at these facilities. The Board has ensured the local community has had significant opportunities for input into these projects.

54. The timing of the commencement of the Urgent Care Centre at Wentworth will be dependent on recruiting the appropriate workforce to ensure continuity of services to the community. FWLHD will also be working with Mildura Base Hospital to ensure any change in clinical services and operations are well understand.

55. FWLHD is also part of the statewide program for essential worker accommodation, with projects underway in Broken Hill and Balranald. This program is critical as there is minimal rental accommodation available within our communities and recruitment is often dependent on being able to provide an appropriate mix of short and medium-term accommodation.

Challenges of Current Funding Models

56. The current funding models do not provide funding beyond the current financial year. In my view, a three-year or three-year rolling service agreement would provide greater certainty for LHDs and staff to operate and undertake improvement activities. It would also provide greater certainty for recruitment.

57. The Ministry of Health allocates revenue budgets on a historical basis, with a model for allocating any growth in revenue targets. An equitable model reflecting each LHD's revenue capacity would be preferable.

58. A number of structural issues with the Commonwealth activity based funding (**ABF**) model are noted below. While these impact the ABF component of the Service Agreement, the Board acknowledges the Ministry of Health does work with the FWLHD

Executive to ensure our facilities receive the funding required to maintain services and is open to considering enhancements and variations to funding to meet the specific circumstances of providing health care in the Far West.

59. The current ABF model is based on the quantum of services delivered in each Health District and regulated under the National Health Reform Agreement[3] between the Commonwealth and State governments. It does not specifically address the level of need within each community and the services required to meet that need. FWLHD has a high level of need for health services due to the underlying health of our communities and limited private healthcare providers across the LHD. The Ministry does provide specific funding in statewide priority areas to enable new or enhanced services to be delivered, partly addressing this deficiency in the ABF model.

60. Broken Hill Health Service is the only ABF hospital in the LHD. The cost of providing services at Broken Hill Health Service in FY23 was $7,846 per National Weighted Activity Unit (**NWAU**), 36% higher than the average state price of $5,756. Higher staffing costs (agency and premium labour, travel costs) and the high cost of operating in a remote location, combined with the limited opportunities to achieve efficiency through scale, are the fundamental causes of this higher average cost. These higher costs are not accurately captured under the current remote allowances within the ABF model.

61. The Commonwealth Government has a number of models to categorise remoteness. The *Modified Monash Model*[4] is used in some Medicare and National Disability Insurance Scheme payment calculations. The *Australian Statistical Geography Standard 2021*[5] determines remote allowances in ABM NWAU calculations. In both of these models, Broken Hill is categorised as *outer regional*, identical to Bowral in South Western Sydney LHD and Blackheath in Nepean Blue Mountains LHD. The FWLHD Board believes Broken Hill, like other towns in FWLHD, should be categorised as remote. Within the ABF model, this would increase the remote activity loading (NWAU) for acute inpatient services in Broken Hill, for example, from 8% to 22% in FY24[6], significantly increasing the activity generated and reducing the variance to the State Efficient Price noted above.

62. Under the current ABF model, two facilities do not receive funding. White Cliffs Health Service provides emergency services, nursing services and RFDS clinic support. It is assumed to be part of Wilcannia Health Service, which is 100km from White Cliffs and operates under separate management. White Cliffs is of a similar size to Tibooburra Health Service, which is funded. Buronga Community Health Service provides community health services across the two rivers region: Buronga, Dareton, Wentworth and Balranald. It is assumed to be part of Wentworth Hospital despite being located 30km from Wentworth and having separate management.

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[3] Australian Government, Department of Health and Aged Care, accessed 30 April 2024: https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra [4] Australian Government Department of Health and Aged Care website, accessed 30 April 2024, https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

[4] Australian Government Department of Health and Aged Care website, accessed 30 April 2024, https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

[5] Australian Bureau of Statistics, accessed 30 April 2024, https://www.abs.gov.au/statistics/statistical-geography/australian -statistical-geography-standard-asgs

[6] "National Efficient Price Determination 2023-24" IHACPA, March 2023, p14