Special Commission of Inquiry into Healthcare Funding

Statement of Melissa Welsh

Name: Melissa Welsh

Occupation: Director Allied Health and Integrated Community Services, Far West 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.

Population served by FWLHD

2. FWLHD has a population of approximately 30,000 people. Close to 18,000 of these people live in Broken Hill and 6000 along the Victorian border. The remainder are located in remote communities across the LHD or at remote sheep and cattle stations.

My role

3. I am the Director Allied Health and Integrated Community Services for the Far West Local Health District (**FWLHD**, **the District**). I have held that role since it was established in 2020. A copy of my CV is at **Exhibit A**. I report to the Chief Executive.

4. The focus of my portfolio is to facilitate the provision of services that provide holistic, collaborative and integrated care. Initiatives within my portfolio are geared towards helping people stay healthy and remain in their homes. An overview of my portfolio is at **Exhibit B**. My portfolio sees me oversee seven teams:

    a. **Integrated care** (Broken Hill and some outreach), which includes the oversight and implementation of programs and initiatives known as Planned Care for Better Health, ED to Community, Vulnerable Families; School Based Nurses, Wellbeing Health In-Reach Nurse (**WHIN**), High Risk Foot Service, Osteoarthritis Chronic Care Program (**OACCP**), Menopause Service, Movement Disorders Service and the Enhanced Chronic Care program.

    b. **Allied Health** – the services supplied by the Allied Health teams include Occupational Therapy, Physiotherapy, Dietetics, Speech Pathology, Social Work, Medical Imaging, Pharmacy. These services are all based within Broken

Hill. They provide inpatient care to patients in Broken Hill Hospital, outpatient services and follow up in the community. Some have capacity to include outreach to some locations in the district.

c. **Child and Family Health Service**, which includes traditional Child and Family Health services (Broken Hill only) as well as the Blood Lead Screening Service (Broken Hill only), Sexual Health Service (District wide), Women's Health Service (Broken Hill only) and Community Nursing (Broken Hill only);

d. **Oral Health** (District wide);

e. **Violence Abuse and Neglect Service** (District wide), which includes Sexual Assault and Medical Forensic Unit, Adult Survivors Program, Child Wellbeing Program, Safewayz, Newstreet, and the Joint Child Protection Response Program (**JCPRP**);

f. **The Project Management Office** (**PMO**) was established in 2020 as part of the Executive Leadership Team restructure. The PMO was aligned to report to my role under the banner of innovation (my previous job title was Director of Allied Health, Partnerships and Innovation) and also because I previously held the role of Clinical Redesign and Innovation Manager in the District. The PMO holds the Clinical Redesign lead as well as a project officer and their role is to lead and support implementation of change initiatives across the LHD. More recently, the PMO has also taken on positions for Redevelopment FFE and Redevelopment Change Manager, and will soon be employing a project officer to oversee the build of the Wilcannia Dialysis Unit.

g. **Other portfolios and initiatives** – such as Disability/National Disability Insurance Scheme (**NDIS**), Health Promotion Unit, and Pregnancy Family Counselling, oversight of a podiatry student clinic in partnership with the University of South Australia, and the agreement with NSW Health Pathology for pathology services provided in Broken Hill.

5. There are 11 direct reports to my role as Director of Allied Health and Integrated Community Services.

6. The Allied Health and Integrated Community Services directorate holds 150 full-time equivalent (**FTE**) positions, and carries an average of 35 vacancies across the directorate each year.

Partners

7. My team has working relationships and/or agreements with:

   a) the Royal Flying Doctor Service (**RFDS**) for oral health in remote sites;

   b) University of South Australia – for a student led podiatry clinic;

   c) the Department of Education - for the School Based Nursing Program, WHIN program, Brighter Beginnings project;

   d) Western NSW Primary Health Network (**Western PHN**) – for example, the PMO manages projects such as Engage Outpatients implementation, various Integrated Care initiatives (such as the Menopause service), and FWLHD's Collaborative Commissioning project;

   e) Rural Doctors Network (**RDN**) – for example, the Collaborative Commissioning project and Rural Health Outreach Funded initiatives;

   f) Western NSW LHD (**WNSWLHD**) and Murrumbidgee LHD – Specialist Intellectual Disability Health Team;

   g) WNSWLHD – shared Heath Promotion service, Virtual Pharmacy service;

   h) Sydney LHD (**SLHD**) – Virtual fracture clinic, new graduate rotating allied health pilot program;

   i) South Eastern Sydney LHD – Sydney Sexual Health (medical governance of the Sexual Health service);

   j) My Emergency Doctor – engaged to support Community Nursing and Integrated Care consumers who are unable to access a GP in a timeframe that will achieve better clinical outcomes for the person;

   k) Headspace – for Violence Abuse and Neglect collaborations;

   l) Mission Australia - for Violence Abuse and Neglect collaborations;

   m) LiveBetter – patient transport to physiotherapy outpatients services via a non-governmental organisation grant;

n) NSW Environment Protection Authority (**EPA**) – data sharing and grant funding for blood lead screening program and related initiatives;

o) iMed – Radiology reporting and on-site radiology services in Broken Hill;

p) Various home care providers – utilise community nursing service on a fee-for-service basis due to the absence of any other private nursing providers in Broken Hill for them to contract.

Collaborative Programs

8. Some recent examples of collaborative programs have been the RPA Virtual Fracture Clinic, the Healthy Steps Program, the Planned Care for Better Health Animation, and the Rad Flag Project. I describe each below.

RPA Virtual Fracture Clinic

9. Launched in April 2023, the RPA Virtual Fracture Clinic is a collaboration between SLHD and FWLHD which allows patients who present to Broken Hill ED with specific uncomplicated fractures to be referred for virtual follow-up care. A virtual physiotherapist from RPA reaches out to the patient at their home to provide a tailored management plan, allowing most patients to avoid the need to physically return to Broken Hill for follow-up appointments. There have been small numbers referred over the first 12 months of the program. Patient feedback has been positive. Patient numbers remain too small for any broader evaluation at this time.

10. The LHD is in the process of negotiating with SLHD for an increased scope for the virtual fracture clinic, to incorporate orthopaedic consultations and address several care coordination problems that impact on outcomes and patient experience under current models. It is anticipated that this increase in scope will also have a cost implication and a business case will need to be developed to explore if this improvement to current service models will be possible.

Healthy Steps Program

11. The Healthy Steps Program was a collaborative effort between the Integrated Care OACPP and the Dietetics Department at FWLHD. The multidisciplinary team consisted of an Exercise Physiologist, a Dietitian, and the Patient Reported Measures Manager.

The primary goal of the program was educating and empowering participants with the knowledge and skills to reduce overall body weight, enhance diet quality, and incorporating regular physical activity, aligned with the gold standard treatment for osteoarthritis conditions. The pilot program was offered face to face.

12. The eight-week program was led by the Exercise Physiologist and the Dietitian, and they initially monitored eight patients who, as a group, demonstrated improved dietary quality, increased activity and weight loss.

13. The program continues to operate with trial of a virtual option during 2024 for those living remotely.

14. The longer-term goal of the program is to offer a pre-habilitation pathway prior to referring consumers to an orthopaedic joint replacement waiting list.

15. The multidisciplinary program has potential for expansion for managing other chronic diseases within FWLHD, such as cardiovascular disease, diabetes, chronic obstructive pulmonary disease, cancer, chronic pain, and mental health conditions. This expansion has not yet occurred in a targeted way and will be planned if staffing levels allow into the future.

Planned Care for Better Health

16. The Planned Care for Better Health (**PCBH**) Animation is a collaborative effort between FWLHD, Limelight Creative Media and the NSW Ministry of Health, aimed at promoting self-management of health conditions through education, assistance in coordinating healthcare and guidance in navigating the local healthcare system.

17. The PCBH team coordinates external and internal services and care providers including allied health services, mental health drug and alcohol, Centrelink, social work, cardiopulmonary services, and others to focus on social and medical support required by the individual.

18. The animation serves as an alternative medium for health promotion, catering to visual and auditory learners and those who face challenges with general literacy and interacting with traditional hard copy material. The animation was uploaded to YouTube in February 2023, and as at 2 May 2024 the video has been viewed on YouTube 313 times. https://www.youtube.com/watch?v=hW-3vwDK96U

19. The video is now embedded on the FWLHD website for Integrated Care, and is currently being adapted for all Integrated Care Teams across LHDs within NSW Health.

20. The Integrated Care team (inclusive of the PCBH program) recently launched a podcast called Far West of Centre which is the next iteration of innovative ways to ensure consumers have access to easily digestible health and service information.

21. The PCBH program is also implementing the ED to Community initiative, whereby people who present to the Emergency Department (**ED**) more than 10 times in a year or who flag as being at risk of hospitalisation based on an algorithm are offered case management and coordinated follow up to attempt to address their needs in the community. This program is in the early stages of implementation at FWLHD and evaluation data is not yet available.

Red Flag Project

22. The Radiographer Comment and Flag model was developed to enable radiographers to promptly communicate detected abnormalities and significant x-ray appearances to ED referrers in real-time, classifying comments into critical, urgent, and clinically significant. Broken Hill hospital was one of five hospitals in NSW which piloted the model for up to twelve months in 2022-2023.

23. In Broken Hill, general x-ray images were, previously, often not formally reported by a radiologist during after-hours or on weekend periods (the radiologists are not based within Broken Hill and reported remotely on all imaging). The model significantly improved diagnostic outcomes and expedited ED patient flow as doctors could finalise treatment plans on the same day and start transferring care to specialist centres or local GPs. The model continues to be used within Broken Hill Health Service.

Diabetes Initiative

24. The Collaborative Commissioning Project recommenced in late 2020 after a pause due to Covid. It is now branded as Care Partnership-Diabetes (**CP-D**). The project has been through various design and redesign phases as a four-way partnership between FWLHD, WNSWLHD, Western PHN and the RDN. The proposals to date for the program have not been fit for purpose for the FWLHD context, due in large part to the limited or absent primary care services across our region. FWLHD is now advocating for an approach that will meet the needs of the FWLHD region, and to pilot an integrated LHD led shared care

model embedded within the PCBH program, to demonstrate patient outcomes in the remaining 12 month funding period.

25. The FWLHD approach to the CP-D program went live in December 2023 and involves people with diabetes being seen within the PCBH program, provided with holistic care to address their diabetes and other chronic disease needs, and supported to transition to ongoing care with their GP if this is an option. The Far West approach has been integrated into the existing PCBH program to ensure that all care needs are identified and addressed within the one program. This ensures the program is as sustainable as possible and using existing resources as much as possible to be as cost efficient as possible by the end of the funding period. In the short time since December 2023, CP-D is already showing some positive patient outcomes and improvements in patient reported measures.

Challenges

GP services

26. FWLHD does not have a properly functioning primary care sector. There may be considerable wait to access a GP appointment in Broken Hill and there is a high reliance on locum GP's in some practices, which impacts on continuity of care for people with chronic and complex conditions. There is a GP outside of Broken Hill in Balranald, who is retiring soon, and a GP VMO in Wentworth from time to time. RFDS provide visiting primary health clinics to remote communities in the north-west section of FWLHD. The lack of GP services is a significant challenge, particularly for FWLHD initiatives that rely upon such services.

Impact of FWLHD population size

27. FWLHD has a comparatively very small population. Statewide health initiatives are often based on population size and it is this basis of funding which limits the ability of FWLHD to implement the initiatives. For example, Pregnancy Family Counselling funding translates to a 0.5 FTE position, so the LHD will need to cobble together money to make the position recruitable to a FTE position. There was also a small portion of funding provided for facilitation within this program which will be insufficient to implement any facilitation pathway. This allocation was based on data available from NSW Health and the NSW Department of Communities and Justice (**DCJ**). As a region with two state borders, vulnerable families may move across states, making NSW Health and DCJ data incomplete.

28. The Sustaining NSW Families (**SNF**) program exists in every LHD across the state. In FWLHD the program currently does not exist, but FWLHD is funded a small amount for additional home visiting beyond the first 6 weeks for families in need. Child and Family Health nurses attempt to manage and support complex families amongst their usual caseload. The SNF program includes access to a multi-disciplinary team to support families for an extended period of time. With waiting lists to access allied health services there is no referral pathway for multi-disciplinary support for these vulnerable families beyond the usual pathway and wait list. In June 2023, an expansion of the program was announced by NSW Health to more locations and LHD's. However, I have been informed that FWLHD does not have sufficient numbers of vulnerable families to be able to deliver the program, and FWLHD remains the only LHD in the state without an SNF program. This was a shock to me, and a lost opportunity in circumstances where FWLHD has four times the state rate for domestic violence in some communities, and vulnerability exists in the majority of communities across the District. FWLHD acknowledges that the SNF program as it exists in other parts of the state may not translate exactly into the FWLHD context, as is the case with many statewide programs. However, a modified SNF program to fit the FWLHD context, geography and community demographics would help to address these unmet needs in this population group.

Data

29. State data relating to FWLHD populations may be unreliable as there are gaps in the data collected by the state due to cross border flows into two states. Additionally, such data as is collected may not be fully representative.

30. For example, the Collaborative Commissioning program initially intended to use ED presentation data and hospital admission data and avoided complications such as amputations data, as a measure of effectiveness of any program. ED presentations are not necessarily an indicator of poor chronic and complex care in the community, nor are they a reliable measure for effectiveness of hospital avoidance strategies as ED presentations in FWLHD are also an indicator of lack of access to timely primary care services. In short, people who might otherwise present to a GP or other primary care instead present to the ED. Avoided complications such as amputations is an unreliable data set as these types of interventions occur in Victoria or South Australia. In some parts of the LHD, community residents may be living in quite vulnerable situations and living with complex care needs, but due to a lack of comprehensive care in the community, are not known to any systems or services until a crisis occurs, and as a data set, do not exist anywhere. Once FWLHD services become aware of these people at the

time of crisis, it is apparent they and the community would have benefitted from preventative and restorative programs that have not been funded, or are inadequately funded, in FWLHD due to what I assume may be gaps in data collected by the state and due to small population numbers. This means that assumptions based on statewide data for the FWLHD, which inform funding allocations, may not be reliable.

Distance

31. In addition to assumptions based on potentially unreliable data sets, and population size, the impact of distance needs to be considered when establishing programs that are expected to cover the District. With close to 200,000 square kilometres to cover from end to end of FWLHD, the travel requirements translate to significant non-productive time in providing services to relatively small populations of people. The closest community to Broken Hill is 1 hour by road, the furthest is 5 hours by road. There is a dependence along the Victorian border on visiting and private services travelling across the border to service NSW communities, resulting in several service gaps for those community members. ABF funding does not reflect the travel time required to provide the service. Virtual care may be an option in some cases, but does not replace the need for face to face services.

32. Remote in-home monitoring is a program the LHD has been using for several years. With the pending transition to new providers and a funding source that supports that transition, the LHD will establish Virtual Support Officer (**VSO**) roles to support and enable the uptake of this program. Clients may require home visits to set up equipment and trouble shoot connectivity or useability issues, which has depended previously on a clinician having capacity to undertake these visits. The program also depends on a clinician being available to monitor the data and a primary health care service to refer the client to in the event of clinical issues being identified by the monitoring equipment. The establishment of VSO roles and a clinician with focused responsibility for the program should see an increase in uptake and address some of the challenges related to distance.

Compact workforce

33. In addition, due to the compact workforce of FWLHD, there is often no existing workforce infrastructure to build from, and/or such a person will have to carry multiple other projects. As with the example at paragraph 27 above, the LHD will need to pull together various parts of a FTE to try to create a full FTE, as part-time FTE are generally not attractive to people re-locating to the region for work. As a result, the position that will be

created will need to cover at least three program areas (including Pregnancy Family Counselling at 0.5 FTE funded, and Safe Start Coordinator which is funded 0.2FTE), be across several policy and compliance areas, and deliver a bespoke service that will be unique in the state. The LHD will invest time and resources into training this person in the various program areas they will be responsible for since there will not be a similar role anywhere else, and support them to practice in a safe and effective manner. When the person takes leave or resigns, it will be difficult to find someone with the skills and experience to cover the vacancy, and as a program of 1 FTE, the program may be suspended in the event of a vacancy. Due to the broad scope of the role and the unique role structure, recruitment to replace the person who has vacated may take a long period of time. This creates a cycle of prolonged recruitment for bespoke roles, extensive training and support, short to medium term program delivery, resignation of the incumbent to return to their home elsewhere, and then suspension of the program until the vacancy is recruited again. This is the fairly regular service delivery experience within FWLHD. It is less than ideal for consumers and is fatiguing for hiring managers who recruit, on board, train, supervise and repeat on a semi-regular basis.

34. Another example of one role carrying multiple responsibilities is the creation of the Disability Navigator role. Unable to recruit to the Specialist Intellectual Disability Health Team (**SIDHT**) clinician funded at 1 FTE for the previous 4 years, and identifying a gap within Broken Hill Health Service of people with disability being in hospital and unable to be discharged, I converted the SIDHT clinician into a disability navigator role, which now means the role is responsible for Disability Navigation for people with disability in hospital (across the District), people with disability in the community at risk of hospitalisation (across the District), SIDHT assessments (across the District) and the Disability Inclusion Action Plan for the District. There is no other funded disability focused role in FWLHD. Since recruitment in late 2023, the role has already had some measurable impacts in saved bed days, avoided admissions and keeping people out of hospital.

35. The other common occurrence is that FWLHD is not funded for roles to deliver a mandatory program, such as to coordinate the Safety Action Meetings as part of the Violence Abuse and Neglect Service, with other LHDs having Safety Action Meetings coordinator roles, so the coordination role falls to the service manager to do the information gathering, follow up, and coordination. This is in addition to carrying many other roles due to vacancies in the team, managing high levels of children and adults at risk across the District, and carrying clinical caseloads. It is a very high expectation of

people who are already in stretched roles to pick up roles that exist elsewhere but are not funded in FWLHD.

36. Another example is the Antimicrobial Stewardship (**AMS**) program. This program is an essential component of reducing antibiotic resistant infections by targeting the over-use and incorrect use of antibiotics. It is a core component of National Standards 3 (Infection Prevention and Control) and 4 (Medication Safety). FWLHD was dependent on a sporadic on-call Infectious Diseases Physician service from a metropolitan hospital and Broken Hill Health Service needed better access to an Infectious Diseases Clinician to assist in leading the AMS program. This is a medical role however due to the gap, and due to the Pharmacy department being located within the Allied Health directorate, the Pharmacy department funded the initial engagement of the Infectious Diseases physician (this has now been moved to the Medical Services Directorate to manage and fund).

37. This then led to the next gap of an AMS Pharmacist being prioritised, with the role needed to facilitate and lead the Pharmacy component of the AMS program. The Pharmacy department did not have an AMS position and with 3 FTE total pharmacists to service the Broken Hill Health Service and district, did not have capacity to redirect existing FTE to this program. As a consequence, the Pharmacy department has disinvested in the shared Pharmacy Intern program with the local community pharmacies (a long-standing program which provides a career pathway for new graduate pharmacists into the hospital pharmacy scope) to fund a 0.5 FTE Virtual AMS Pharmacist. The implementation of the AMS Pharmacist role in 2023 has resulted in improved AMS outcomes, however it has come at a cost to the intern program in the context of the Pharmacy department not being able to fill all vacancies for several years.

Allied health

38. Historically, there has been an underinvestment in Allied Health roles within FWLHD. Since the establishment of the Director Allied Health and Integrated Services role, there has been more advocacy to capture available funding and build multi-disciplinary programs. However, there remain no funded Allied Health FTE outside of Broken Hill, and no identified funding streams at present. The Broken Hill Allied Health teams are small and have waiting lists for the services within Broken Hill. When fully staffed, some of the larger teams (for example Occupational Therapy and Physiotherapy have 7 FTE) provide limited outreach services to remote communities in the north-western sector of the LHD, however there is no outreach to the southern sector.

39. As I explained at the beginning of this statement, FWLHD has a population of approximately 30,000 people. Close to 18,000 of these people live in Broken Hill and 6000 along the Victorian border. The remainder are located in remote communities across the LHD or at remote sheep and cattle stations. The communities along the Victorian border have very limited access to Allied Health services.

40. Rural Health Outreach funding underspend is directed each financial year to funding a few hours per week of Occupational Therapy and Physiotherapy for Buronga HealthOne and Wentworth Hospital. This underspend is identified each financial year based on vacancies or in decreased activity from agreed programs, and by agreement between the RDN and FWLHD, it is directed to the above Allied Health services. If there is no underspend, there will be no funding directed to the Allied Health services that Buronga and Wentworth partially rely upon. Historical funding from the Outback Division of GP era (now administered via the Western PHN) funds Robinvale Community Health in Victoria to provide visiting Allied Health services to Wentworth and Balranald facilities.

41. There are no community based (home visiting) Allied Health services along the southern part of the FWLHD therefore it remains unknown how many consumers are at risk in their homes due to environmental or mobility risks that could be modified to prevent injury or harm.

42. There are only private Allied Health services for children along the Southern part of the FWLHD, which means families need a funding source such as NDIS or ability to pay to access paediatric Allied Health services in NSW in the communities along the Victorian border. There are limited paediatric Allied Health services in Mildura (Victoria).

43. There is no capacity to redirect Allied Health from Broken Hill to address these gaps. For example, there are 3 Speech Pathologists in Broken Hill when fully staffed, providing service to the hospital and children in the community, with extensive waiting lists. Diverting any resource elsewhere will result in closure of services within the highest population area of FWLHD.

Ultrasound services

44. There is also no publicly funded ultrasound service within NSW along the Victorian border of FWLHD. Residents need to travel to Mildura or Swan Hill to access ultrasound services and pay for scans. The Coomealla Health Aboriginal Corporation has reported that pregnant women are opting not to travel to access important staging ultrasounds due to the cost. The Broken Hill Health Service Medical Imaging department is aware

and will explore if a visiting sonography service may be possible. However, with 1.4 FTE qualified sonographers in the department, and an inability to recruit sonographers due to a broader shortage within this workforce group, any outreach will result in there being no sonographer on site in Broken Hill some days (which will impact on ED patient flow).

Statewide network services

45. Access to support from specialised 'statewide' services (such as spinal injury and amputees) is limited or non-existent. FWLHD Allied health clinicians liaise with the providers in Adelaide for spinal cord injury and amputations in getting guidance for any patient needs that are beyond the expertise of the treating clinicians.

46. Statewide outreach services are inconsistent in their coverage of the state. The spinal cord outreach service has previously only gone as far West as Cobar (500km from Broken Hill), hence the dependence on Adelaide for support and ongoing care coordination. This also creates difficulties in prescribing equipment when the assessing clinician is in South Australia but the FWLHD clinician needs to navigate the Enable NSW processes for the patient. It takes considerable time and care coordination to meet the needs of these types of consumers when they return to NSW following their time in South Australia.

47. One exception to this is the Motor Neurone Disease (**MND**) NSW, who have actually visited Broken Hill and provided support to clinicians in working with consumers who have MND. MND NSW were also able to provide equipment and other assistive technology to consumers.

48. Another example of mismatched statewide coverage is the Royal Far West (**RFW**) service for children. FWLHD is aware that RFW is seeking an expansion of their services to include Regional Assessment Clinics. FWLHD has been informed that should the outreach model be implemented, these clinics would be in Wagga Wagga and Dubbo (at least 9 hours drive from Broken Hill). With high vulnerability and unique challenges to child development outcomes (such as the environmental lead exposure issue in Broken Hill and the socio-economic challenges in remote communities) there will be little to no benefit from this program for families in FWLHD.

Opportunities

Lead exposure

49. Endemic lead exists within Broken Hill as a legacy of mining operations, and children are exposed to environmental lead within Broken Hill.

50. Broken Hill Child and Family Health Team operate the Blood Lead Screening program. The blood lead screening program has operated since the early 1990's and continues with limited recurrent LHD funding for 1.8 FTE. The program is dependent on EPA grant funding for provision of the full screening and home visiting service. Without grant funding, the service is limited to screening and education only. There is no funded Allied Health within the program and any children identified with developmental vulnerability are referred to the general paediatric Allied Health waiting lists. The Broken Hill Environmental Lead Response Group has been established in late 2023 to review the existing program and develop an ongoing strategy for lead management in Broken Hill. The group is chaired by the Department of Regional NSW and includes Aboriginal Affairs, Crown Lands, EPA, Mining, Exploration and Geoscience (MEG), Health Protection at the Ministry of Health, FWLHD, Department of Education, Broken Hill City Council, Maari Ma Aboriginal Health Corporation, CBH Resources, Perilya, Transport for NSW, and the Aboriginal Housing Office. There is an opportunity to develop a holistic program that expands from being a screening and remediation focused program to proactively assessing and managing the health impacts of lead exposure in children. This is a population health priority for FWLHD and requires investment to expand the program to manage the health impacts on an ongoing and longitudinal basis. There is also opportunity to engage in research to address gaps in current evidence about the impacts of endemic lead exposure on children and through their lifespan.

Oral Health

51. Recent investment by the Ministry of Health Centre for Oral Health to address significant service gaps in FWLHD's Oral Health service has addressed longstanding issues in the service model. The impacts of this investment are yet to be realised as the recruitment is yet to commence. The service is expected to run over budget while undertaking catch up work (for example, issuing denture vouchers and addressing the denture waiting list that currently extends to 2019) and National Partnership Agreement (**NPA**) funds are consumed with supporting 'Fly in Fly Out' for the dentist and locum coverage, which means there are limited NPA funds left for vouchers. The LHD has been funded for 1

FTE dentist and SLHD has been funded for 1 FTE dentist to rotate to Broken Hill for 2 weeks at a time (creating a second dentist within the clinic). This model depends on SLHD recruiting two dentists and rotating them to Broken Hill through the year. This creates the opportunity to double the clinic capacity to provide services. Unfortunately, SLHD has been unable to attract applicants for the roles and are now in a recruitment freeze. This leaves FWLHD oral health service vulnerable with one dentist on site 3 weeks a month and dependence on locums for any other service capacity.

MRI

52. Broken Hill Health Service is the only base hospital, and there is no major tertiary facility within FWLHD. The hospital does not have an MRI. Private providers in the community have installed two MRI machines in recent years. MRI is now expected by visiting clinicians as a standard imaging modality, and not having an MRI within Broken Hill Health Service has resulted in logistical challenges in transporting inpatients off site to access MRI. Being off site means the private MRI services are available only in business hours and for medically stable cases. There is no access to urgent or emergency MRI (in hours and out of hours) for patients attending the Broken Hill Health Service. FWLHD has identified a suitable location for an MRI within the hospital footprint and is exploring options to obtain an MRI to better cater for emergency and inpatient needs. Access to funding will be required to support the ongoing provision of this service, such as maintenance costs, and 1 FTE radiographer to operate the machine.

Virtual care

53. Virtual care is an enabler to address barriers in access to care as a result of geography. Virtual care is becoming more mainstream and accessible to consumers. The infrastructure required to deliver quality virtual care is progressively being installed in various locations across the services and programs are emerging trialling virtual options. Any expansion of virtual care will require investment of Virtual Support Officer type roles (to support both ends of a consultation) as well as increased clinical FTE.

54. In my view, existing clinical staff will only be able to embrace virtual care if it replaces face to face appointments, which is not the intent of virtual care. This is because clinics and clinicians are already running at full capacity and any expansion (whether face to face or virtual) will only be possible with additional resources. Incorporating virtual care in place of face to face consults is possible within existing resources if this aligns with the consumer need and clinical intervention being provided. To be a true enabler of

increased access to care, it will require investment in additional clinical resources to work virtually in addition to traditional and complementary face to face services.

Melissa Welsh

Witness name: Helen Hayes

22/5/2024

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Date

Date