Special Commission of Inquiry into Healthcare Funding

Submission Number: 5

Name: Murrumbidgee Local Health District Board

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Murrumbidgee Local Health District Board Submission to Special Commission of Inquiry into healthcare funding

Introduction

The Board of the Murrumbidgee Local Health District (MLHD) provide the following contribution to assist the Commissioner in his Inquiry in relation to Section B of the Special Commission Letters Patent, in particular:

The existing governance and accountability structure of NSW Health, including:

> *i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);*
> *ii. the engagement and involvement of local communities in health service development and delivery.*
> *v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health of the NSW population.*

The Board acknowledges that the health system is complex, has multiple players and layers of bureaucracy. Further, that the NSW Ministry of Health functions relate to regulation, public health and administration of the health system.

The Board welcomes the opportunity to share a rural and regional perspective and recognises the financial challenges that face governments at national, state, and local level.

The current devolved decision-making system incorporating a Local Health District Board approach, commenced in NSW in 2011 and has matured in the past 12 years.

Devolved decision making to a local level in NSW has two aspects, the governing Board and the operating entity. In this case the Murrumbidgee Local Health District.

It is possible for a Local Health District to be governed without the existence of a governing Board; it is also possible to implement other models of organisational design. This submission seeks to provide a Board perspective on the strategic, economic and social benefits to government of devolved governance and decision-making structures.

'Fit for Purpose' Governance models for a contemporary Health system

Current 'Board based' model.

Independence

The functions and powers of the Board of an LHD are rooted within the Health Act of 1997. The Board is empowered to set the strategic direction and oversee the management and performance of the organisation. The Board in partnership with the Chief Executive sets the tone and culture of the LHD.

Board members are appointed by the Minister and are independent from the bureaucracy.

This independence means that the Board can exercise heightened due diligence and can act with impartiality in the interests of key stakeholders in the provision of strategic direction, oversight of business and quality assurance, organisational performance, optimising value creation and exercising financial stewardship.

Members are diverse and contribute broader expertise, business acumen and community perspectives.

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Local Boards look across the operations of the District and the clinical and professional interests. The Board act as a collective, focused on outcomes and whole-of-District interests rather than individual interests and single community perspectives.

Local intelligence and value creation

The current Board/LHD structure provides:

- timely access to local knowledge of the contemporary social, economic and cultural environment within which the organisation delivers service responses,
- provides insight and perspectives resonant with the communities which they serve and 'lived experience' of the unique geographic area for which the entity is responsible, and
- engages local people with passion and expertise in testing assumptions, galvanising the support and trust of communities as well as optimising engagement with key stakeholders.

Whether Board-based or an alternative governance model, a more localised governance system has a better understanding of the unique community needs, has established relationships with community organisations (especially local government) and networks as well as other bodies such as Primary Health Networks

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Cost of good governance versus the cost of governance failure: size matters

The cost of the current localised governance structure at Board level is $285,000 in the MLHD, covering the sitting fees and ancillary costs of approximately 10 board members. Members also provide volunteer time to meet the needs of the organisation, particularly in rural and regional areas where relationship building and leadership require both virtual and 'face-to-face' presence to instil community confidence, build strategic alliances, model accountability and transparency and hear the views of key stakeholders. Adding the cost of LHD executive servicing the Board, the real cost is $475,000.

The return on this investment by government can be measured in tangible and intangible ways. The governance model can lead to increased productivity, enabling people to work locally, asset-sharing resulting in reduced fixed costs and localised process improvements.

The intangible benefits are significant, leading to enhanced consumer trust and experience. Increased community confidence is demonstrated by community willingness to engage in co-design and communities engaging in championing or participating in health promotion and pathways to employment within the health or ancillary service system. For example, the MLHD "Grow our Own" strategy is a collaborative partnership with local high schools, TAFE NSW and Training NSW, which has seen more than 60 young people complete their higher school certificate with vocational qualifications in healthcare fields with employment opportunities.

Effective local governance is vital to improving patient safety and quality of health care services.

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The MLHD Board and executive leaders have implemented governance systems to set, monitor and improve the performance of the organisation and communicate the importance of the patient experience and quality management to the workforce and communities. Size matters: achieving this across 47 facilities including 33 hospitals is feasible however, the effectiveness may lessen with larger areas and services.

Beyond the Board to the Local Health District

Geographic reach and organisational effectiveness

It is possible to redraw boundaries, increase the geographic reach, reduce the geographic reach or shift the model to hub and spoke models. Each model has its benefits and risks. From an oversight perspective, the acuity of vision and capacity for connectivity is critical. There is a tipping point at which an efficiency premium comes into play.

Zoom in 'too closely' and use smaller building blocks for oversight and management creates an opportunity for increasing costs, reducing quality of care and organisational effectiveness, for example:

- parochialism and restrictive practices,
- increased volume of checks and balances,
- need for stronger systems and increased centralised coordination.
- decreased capacity for resource sharing or cross sector collaboration,
- increased community 'capture' and potential for resistance to change,
- increased risk of reduction of labour or clinical capacity, and
- increased risk of divergence from statewide frameworks of policy and clinical practice.

Zoom out 'too far' and use larger geographic or population catchments at a time of fiscal restraint may:

- reduce the acuity of oversight systems introducing additional risk,
- increase the reach for leaders already at optimum capacity,
- increase the need to invest more to strengthen systems to support performance and due diligence,
- require enhancement of quality business assurance and clinical practice quality assurance systems,
- reduce the connection to organisational culture and sense of identity resulting in staff disengagement,
- create a view of community that is homogeneous and reduces the capacity to target and respond effectively to community needs,
- reduce community identity and connection with the organisation resulting in a loss of 'goodwill' and co-contribution,
- increase the opportunity to undermine ethical behaviour and organisational culture, and
- fracture existing boundary alignments which may either inhibit partnerships and collaborative arrangements or increase the cost of maintaining alliances across unaligned boundaries.

Local governance structures can better establish relationships with communities and organisations. The MLHD Local Health Advisory Council (LHAC) system draws on local groups of citizens from each community surrounding each of the 33 Hospitals and Multi-Purpose Services. The LHAC system is a means of growing health leadership, place-based planning and improving heath literacy in communities. LHACs provide community input to the LHD service system planning, community education and an avenue for trust building and gauging community sentiment. The MLHD Board connection to the LHAC system is through:

- monthly consolidated report of LHAC activities,
- bi-annual, whole of LHD LHAC forums co-sponsored with Primary Health Network, and
- a schedule of annual LHD Chief Executive/Board Chair visits to each of the LHD facilities that includes a forum with local LHAC members and available local government representatives.

These connections strengthen the community engagement and governance of the District. Regardless of the decision, in relation to the assessment of the need for a governing Board, the present MLHD Board would argue strongly that the current LHD boundary is effective and provides the best alignment of geographic spread to secure effective, efficient and responsive quality health care at this time. The existing boundary also offers the opportunity to understand preferred community flows within and between communities as well as cross-border traverse to enable accessibility.

Any change to the boundary could disrupt existing partnerships and collaborative arrangements and incur additional expenses due to required changes to signage and administrative systems.

Local governance structures can better establish relationships with communities and organisations.

Contemporary planning and service design

In a rural and regional context, changes in rural communities are occurring;

- growing satellite communities close to regional centres as well as small, more isolated communities, require place-based initiatives,
- patient and community needs must be the starting point for planning and innovation. The LHD is best placed to identify and understand this. It is closest to community and can leverage existing and longstanding alliances with key partners and fellow providers to create better patient care pathways and a more integrated response (e.g., the pioneering rural generalist general practitioner training model), and
- achieving place-based codesign requires the support of experts. This process is most successful when both local and metro experts and communities are actively engaged in codesign. Codesign builds confidence and engagement with community.

Major developments are occurring in information technology and communication with rapid development even in small communities. Learning from the COVID-19 pandemic and workforce shortages have led to resilient innovations in virtual care and the use and community acceptance of technology-assisted access. While these developments assist in supporting access to clinical expertise, more work needs to be done to ensure equitable and timely specialist interventions, procedures and interactions with specialist services.

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No one-size fits all for rural and regional communities and diversity of communities is a challenge for those not regionally based.

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Healthcare safety and quality must be carefully considered by the executive leadership team and the Board during these developments. This requires local understanding and education of patients and other key stakeholders in digital literacy. The linking of virtual care with metropolitan tertiary networks is vital and contributes to rural workforce development and retention.

Equity in Health Care

Partnerships with the NSW Ministry of Health, the Clinical Excellence Commission, academia and other key stakeholders ensure that the LHD operates within a framework of regulation, policy, clinical governance and best-practice.

The MLHD catchment is 125,243 square kilometres serving 249,164 people. Populations are grouped in large regional centres, towns, villages and farming properties.

NSW Health identifies equity as one of its basic tenets. In rural and regional settings this equity is seen as equity of access to quality, culturally safe and timely health care from skilled clinicians.

In MLHD, the District continues to innovate, adopt emerging technologies, create alternate solutions or enhancements to service models to address the impact of distance, workforce challenges and the changing nature of population driven need. Examples include:

- integrated care pathways and services,
- mobile services, and
- technology assisted access to specialist care.

Community expectations and experience require nuanced engagement and understanding to ensure the needs of regional cities and rural towns are addressed in a way that strengthens the physical, social, and economic health of communities.

The District continues to contribute to building a rural and regional evidence base to support excellence in rural health care through initiatives such as the Murrumbidgee Health and Knowledge Precinct.

The Murrumbidgee Health and Knowledge Precinct brings together health partners, industry and our local communities to design innovative and practical ways to provide rural people with exceptional healthcare. The Precinct is building on the ties between commonwealth and state services, which is the key issue that bedevils rural and regional health. This is a collaboration between hospital and community care, government and non-government providers, and Aboriginal-governed services.

Access to healthcare is enhanced with strong community engagement and understanding to ensure the needs of people are addressed in a way that strengthens the physical, social and economic health of communities.

Conclusion

This submission has provided a regional and rural perspective of a complex and dynamic health system. The Board believes that the maintenance of the current model of sound governance, connected to local participatory process is critical to scaffold a robust, efficient and world class, patient-centred health system.

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Further, the Board believes that any change to Local Health District geographical boundaries, at this time, could break shared catchments and communities of practice, disrupt existing alliances and partnerships endangering any current or future gains, increase costs by requiring rebranding and system realignment and lastly, impact the current open and patient-centred organisational culture evident across the Murrumbidgee Local Health District.

The Board strongly supports the Chief Executive and her team as they focus on improving health outcomes in rural and regional NSW by adopting new technologies, building evidence-based solutions and reshaping our services or health pathways to build more contemporary, patient-centred models of care.

Acknowledging our Aboriginal communities

MLHD acknowledges the Traditional Custodians of the lands across our footprint, traditional lands of the Wiradjuri, Wamba Wamba / Wemba Wemba, Perrepa Perrepa, Yorta Yorta, Nari Nari and Muthi Muthi nations. We recognise their continuing connection to lands, waters and communities. We pay respect to Elders past, present and emerging.