New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 27

Name: Hunter New England Local Health District

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Hunter New England Local Health District

13 November 2023

Mr. Richard Beasley SC
Special Commission of Inquiry into Healthcare Funding
Email to: submissions.hfi@specialcommission.nsw.gov.au

Dear Commissioner,

Thank you for the opportunity to make a submission to the Special Commission of Inquiry into Healthcare Funding on behalf of Hunter New England Local Health District.

I recognise the importance of this Inquiry in assessing the health system's funding and governance, as well as opportunities to deliver higher quality, more timely and accessible patient centred care.

Hunter New England Local Health District covers an area spanning 131,785 square kilometres. Our district provides a range of public health services to almost 1 million people across the Hunter, New England, and Lower Mid-North Coast regions.

With more than 18,000 staff and volunteers, working across more than 120 facilities, we are the only local health district with a major metropolitan centre, several large regional areas, and many smaller rural and remote communities.

The greatest challenge faced by Hunter New England Local Health District is our workforce, as attracting and retaining skilled health workers across all settings is increasingly difficult.

The challenge of attracting specialists is being felt in the district across both private and public sectors, adding further challenges as many of the public workforce provides services across both sectors.

This issue spans all types and levels of our workforce and includes nurses and midwives, junior medical officers and specialists, allied health professionals and ancillary staff.

As a result. We are heavily reliant on high-cost agency staff and locums, which has a significant impact on our financial sustainability.

For the 2023 financial year, our district had a total budget of $2.8 billion, with the net result against budget being unfavourable by $21 million. This budget was invested in our people (62.7%), followed by patient costs (14.4%), as well as repairs and maintenance (7.0%).

This 2023 financial year result was significantly impacted by the premium cost of labour. **Appendix 1** quantifies and provides details of that impact amounting to $55 million.

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A comprehensive system-wide reform is necessary to address these challenges. The existing structures do not allow for a funding distribution that aligns with the diverse services a district like ours provides across multiple settings.

As a result of these workforce challenges, we have not met benchmark against many of the performance targets aligned to NSW Health's strategic priorities. In the last financial year:

- 446,934 people presented to our emergency departments.
- 20.3% of patients who were admitted from the emergency department were transferred to a ward in less than 4 hours, 7.8% less than the previous year (target 50%).
- There was a 6.46% increase in ambulance arrivals particularly at our larger centres as many of the smaller facilities struggle with the staffing mix required to accept more acute patients.
- 78.3% of patients were transferred from ambulance to the emergency department in less than 30 minutes, 0.8% less than the previous year (target 90%).
- 31% of patients were discharged from wards before midday (target 35%).
- While we performed less surgeries overall (61,134), the number of emergency surgeries increased by 1.3%, impacting our ability to perform planned elective surgery within appropriate timeframes.
- 21.9% of the 2.6 million non-admitted services provided, were delivered as virtual care consultations. Our services pivoted during COVID-19 but we have continued to prioritise this model- of care

Despite the challenges in performance, the district has worked hard to develop innovative models of care, in areas of virtual care and telehealth. This has provided opportunities to work within existing funding structures and combat staffing challenges, to ensure the delivery of safe and quality services to communities, regardless of their geographic location. We acknowledge more needs to be done, however we are proud to say that we have explored many opportunities to increase our efficiency.

In **Appendix 2** we have listed several areas of innovative practice which could be transferable to other districts, and we could supply more detail if requested.

In response to the terms of reference set out by the Inquiry:

A. **The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future**

B. **The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW**

The current funding model for local health district's prioritises acute services over community health, with around two-thirds of the budget coming from activity-based funding. This model does not account for the service differences between rural and metropolitan areas, placing a strain on rural facilities.

The ABF model does not currently prioritise moving to newer models of care that focus on keeping people out of the acute hospital setting. This is particularly significant for our smaller services.

Further, the national weighted activity unit (NWAU) system does not accurately account for the higher costs of providing services in rural regions. This is particularly relevant as premium labour costs, goods and services continue to escalate. One example of this is the costs associated with patient transfer. The size of the district, coupled with the smaller facilities requiring increased support from larger centres means we are moving a greater number of patients across more

kilometres taking more time and at significantly greater cost, which is unfunded as part of the NWAU.

As a result, facilities in metropolitan areas, particularly John Hunter Hospital, subsidise and underwrite the more expensive rural health services across our district.

The John Hunter Children's Hospital (JHCH) also faces additional challenges in funding compared to other children's hospitals in the state. Established in 1995, JHCH is based in Newcastle, and serves as both a tertiary referral hospital and the primary outreach service for Northern NSW.

Unlike the Sydney Children's Hospital Network (SCHN), which is funded separately as a dedicated tertiary/quaternary children's service with a substantial budget, JHCH competes for funding within Hunter New England Local Health District's budget. This limits their ability to enhance services and infrastructure.

While SCHN has received recent infrastructure investments of $1.5 billion, JHCH lacks dedicated built infrastructure and operates across five major care facilities, leading to staff dislocation and inefficiencies. JHCH also struggles with inadequate staffing for tertiary services, resulting in the reliance on adult services with paediatric skills. Unlike SCHN, JHCH does not have dedicated funds for essential specialties, such as paediatric cardiology, contributing to service inefficiencies.

Despite being the largest neonatal intensive care unit (NICU) in NSW and having a dedicated paediatric intensive care unit, JHCH receives no specific funding for tertiary services supporting these critical facilities. These units require several support services attached to them to provide adequate support to sick kids. The way JHCH is currently funded means that we rely on specialist teams in Sydney providing this support, virtually rather than delivering them locally.

JHCH provides non-funded outreach specialist paediatric services throughout northern NSW, stretching already limited resources. We deliver these services unfunded because families not in metropolitan centres would not have access to them otherwise.

While recent enhancements in gender, palliative care, and chronic pain have garnered dedicated state-based funding for JHCH, challenges persist in areas such as virtual care, where funding is provided via another tertiary children's hospital. Overall, the funding disparities between acute and community services, as well as the competition for resources within our district's budget, pose significant obstacles for JHCH in delivering optimal paediatric healthcare for our region.

Many of these issues could be addressed if we were funded in the same manner as the SCHN.

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency.

NSW Health's **Time for Care** program aims to reduce unnecessary administrative tasks and increase focus on patient care. Frontline clinicians, including those from our district, actively participate in identifying and addressing these tasks. Recommendations from NSW Health for state-wide and local initiatives are being implemented, but significant focus on reforming rostering practices, streamlining clinical information systems and reforming patient administration practices will be key initiatives to reducing the burden on our already stretched staff.

The **Collaborative Care** program was initiated in 2020 to address elective surgery backlogs during the pandemic.

The unintended consequence of the program saw workforce issues exacerbated by increasing private sector services, leading specialists to prefer private over public employment. As a result, we are finding it difficult to recommence elective surgery at our full internal capacity now that collaborative care will end on December 31, 2023.

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F. **The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services:**

Recruiting and retaining health workers, particularly medical specialists, nurses and midwives and allied health professionals, pose significant challenges for Hunter New England Local Health District.

Our district faces difficulties maintaining medical coverage, especially in regional and rural areas, as recent graduates and senior clinicians increasingly prefer metropolitan locations and other states with better award conditions. This issue impacts our district financially, clinically and in the delivery of services.

A state-wide mandate that includes a fixed number of specialists in acute metropolitan hospitals, restricting Medicare licenses to geographic areas and an award that rewards those that work in rural and regional areas are potential strategies that could be considered to address this issue.

Medical

There is a major deficit of junior medical officers (JMOs), with a lack of permanent senior staff to provide supervision and training. The allure of better awards in other states and lucrative locum positions makes retaining junior staff difficult, resulting in significant vacancy rates, particularly in our emergency network. At end of October, 50 JMO vacancies exist.

Generally, attracting medical specialists to regional areas is increasingly challenging, leading to an inappropriate reliance on locums. For example, 95% of Armidale Hospital's emergency department is staffed by locums. The inability to attract anaesthetists affects the delivery of obstetric, surgical, and critical care services. Consequently, this has downstream impacts with our larger hospitals such as John Hunter Hospital and Tamworth Hospital having to provide support, thus creating further capacity and resourcing challenges.

When we successfully attract senior doctor candidates, they are international medical graduates. There are long waits on visas as well as AHPRA/college processing for these candidates. In addition, meeting AHPRA supervision requirements are a challenge as we do not have permanent senior staff to supervise in many of our rural locations.

At the end of October, 32 senior medical specialist vacancies exist.

The district resorts to engaging locum agencies to maintain coverage, but the competitive market has led to escalating rates and unreliable coverage. With many staff specialists' rates capped by their contract with NSW Health, working side-by-side with locums earning triple the amount for the same work, we are seeing an increasing number of workforce issues and disenchantment from our permanent staff.

As an example, our district has received requests from various specialists for higher, outside award on-call rates. We are also increasingly seeing staff take leave without pay from their metropolitan hospital roles, to take advantage of locum rates being offered in other parts of our District.

Rural facilities also heavily depend on GP Visiting Medical Officers (VMOs), but recruitment and retention challenges persist, especially in procedural specialties. The current award and agreements do not incentivise GPs to work in rural facilities and many are not prepared to work for a fee for service payment.

Nursing and midwifery

Recruitment and retention of nursing and midwifery staff present significant challenges for the Hunter New England Local Health District. Despite continuous recruitment efforts, vacancies have risen over the past two years, exacerbated by increased clinical expectations due to a shortage of medical officers. Staff are often required to work overtime and extended consecutive days,

impacting on wellbeing. At the end of October 2023, we currently have 211 nursing and midwifery vacancies.

In instances where our district cannot secure enough nurses, services such as the Wee Waa Health Service are forced to reduce their hours of operation. Further, the scarcity of midwives is impacting maternity services in rural areas, with some of our facilities downgraded or unable to offer midwife-led services. Multi-purpose services face staffing challenges, affecting both healthcare delivery and provision of care to age-care residents who live in these facilities.

Challenges in securing an appropriate skill mix persist in smaller rural facilities, contributing to an inability to meet nursing hours per patient day and award obligations. Although virtual ED medical support has been successful, some rural facilities struggle to fill nursing shifts, hindering the activation of virtual medical support services requiring an on-site registered nurse.

Private nursing agencies, offering higher rates than NSW Health awards, make it increasingly difficult to employ nurses locally. The use of short-term agency nurses also leads to inconsistent care provision. Variances in pay rates between states, along with administrative complexities in transferring between states, further compound the staffing challenges, especially for those living near the border.

NSW's lack of participation in shared databases adds to the paperwork burden for agency nurses moving between states, and LHDs contrasting with simpler processes in other regions.

Allied health

Recruitment of allied health staff is also impacted, with non-government organisations and NDIS providers offering higher pay often for less demanding work, resulting in the reduction or closure of allied health services in smaller towns.

At the end of October, 39 allied health vacancies exist.

This impacts the broader health system, causing delays in patient discharge from hospitals, contributing to bed block issues in larger facilities, and hindering the timely provision of Allied Health care to other inpatients due to increased long-stay patients.

G. Current education and training programs for specialist clinicians and their sustainability to meet future needs.

Our district continues to investigate different ways to attract and retain talent, including via our international medical graduate program. Since 2016, our district has hosted bi-annual orientations for these graduates, contributing significantly to the medical workforce, with over 30% being program alumni. The orientation program prioritises cultural integration and professional expectations, focusing on adapting to the Australian working environment.

Further, our workplace-based assessment program, initiated in 2011, has achieved an impressive 99% pass rate, surpassing the 15-30% pass rate of the AMC examination-only approach. This program has become a leading model in Australia, adopted by more than 20 other centres. There are still challenges ensuring we have enough senior medical staff to appropriately supervise these international medical graduates in the hospitals.

Additionally, each internal network within the district has tailored education programs and mandatory training. A new strategic education committee aims to streamline mandatory training for the medical workforce, focusing on essential tasks to optimise staff efficiency and care provision.

H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation.

A number of innovations have been developed by the district, too many to list in this submission. Examples of two of our more advanced innovations are included in Attachment 2 and following are two newer initiatives that we are in the process of rolling out.

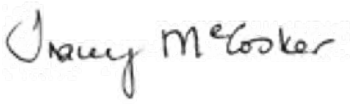
Innovations in healthcare delivery within Hunter New England Local Health District include the establishment of an ADHD clinic for timely diagnosis and treatment of children aged 6-12. This shared-care model involves a team of clinicians offering assessments, diagnosis, and follow-up care through outreach services.

Virtual care has played a pivotal role in addressing healthcare demand challenges, allowing clinicians to manage patients across various settings. Our district is creating a dedicated virtual care service to integrate with existing programs, ensuring safe and effective care, improving access, and enhancing efficiency. It is however difficult to find the funding internally to invest in this while managing so many budget challenges including significant efficiency targets.

Finally, the $2.3 million Health Innovation Living Lab, a partnership between the district and the University of Newcastle, focuses on digital health, sustainability, medical technology, and operations. The lab facilitates collaborative projects, including bio-fabrication services using 3D printing for surgery planning and virtual reality training through the University's Centre for Advanced Training Systems.

Hunter New England Health is deeply committed to our communities and ensuring that we can provide excellent care to our communities, no matter their location within the district. We care for our staff and strive to deliver them a more sustainable health care system that they can thrive within. While the challenges are complicated, we remain optimistic about the future of public health care and look forward to partnering with the state and federal governments on any reform that is proposed.

Sincerely,



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FY23 Full Year Result Analysis

Account Type	Major Category	Monthly Performance Reporting Grouping	YTD Actuals	YTD Budget	YTD Var $	*Recognised Structural Issues*	Revised Result	
Expense	**Total**		**2,853.12**	**2,828.94**	**(24.18)**	**55.02**	**30.84**	
	SALARIES AND WAGES	**Total**	**1,638.56**	**1,625.33**	**(13.23)**	**29.58**	**16.35**	
		Administration	188.75	191.00	2.25		2.25	
		Allied Health	150.72	161.29	10.57		10.57	
		Extraordinary Payments	1.57	0.00	(1.57)		(1.57)	
		Maintenance	9.46	10.62	1.16		1.16	
		Meal Entertainment	(1.78)	(1.36)	0.43		0.43	
		Medical	335.56	341.99	6.43	18.04	24.47	Locums
		Nursing	704.39	674.12	(30.27)	11.54	(18.73)	Agency and high cost nursing
		Other/PSS	98.22	102.05	3.83		3.83	
		Salary Packaging	(19.33)	(23.34)	(4.00)		(4.00)	*Locums and vacancies contribute to deficit given they are unable to Sal Pack*
		Superannuation	148.34	147.76	(0.58)		(0.58)	
		Workers Compensation	22.66	21.20	(1.46)		(1.46)	
	VISITING MEDICAL OFFICERS	**Total**	**124.66**	**121.84**	**(2.81)**	**11.00**	**8.19**	Locums
	GOODS AND SERVICES	**Total**	**890.47**	**882.32**	**(8.16)**	**14.44**	**6.28**	
		Admin	37.69	79.95	42.26		42.26	
		Agency Costs	14.05	3.78	(10.28)	5.32	(4.95)	Commissions paid to medical and nursing agencies, and direct nursing contractors
		Ambulance	25.79	27.02	1.24		1.24	
		Blood Products	11.54	10.93	(0.61)		(0.61)	
		Collaborative Care	52.40	10.51	(41.88)		(41.88)	*Outsourced activity to private hospitals*
		Compacks	1.63	1.78	0.15		0.15	
		Domestic Supplies	11.59	10.00	(1.59)		(1.59)	
		Drugs	47.44	44.54	(2.90)		(2.90)	
		E-Health Charges	35.19	35.14	(0.05)		(0.05)	
		Food	2.70	2.43	(0.27)		(0.27)	
		Fuel, Light & Power	21.02	21.12	0.10		0.10	
		Grants to NGOs	5.82	5.97	0.15		0.15	
		High Cost Drugs - Exp	57.17	56.79	(0.38)		(0.38)	
		HSS Charges	109.77	108.50	(1.27)		(1.27)	
		Imaging	4.48	12.10	7.61		7.61	
		Linen	12.59	13.78	1.19		1.19	
		Medical / Surgical	91.26	91.11	(0.16)		(0.16)	
		NEPT Charges	22.29	21.02	(1.26)	1.26	0.00	Patient transport costs from R&R (including fixed wing transport)
		Pathology	54.04	50.95	(3.10)		(3.10)	
		PPP & 3rd Schedule	171.51	170.70	(0.81)		(0.81)	
		Property and Lease Costs	11.22	8.70	(2.52)	1.33	(1.20)	Rent and short term hotel accomodation for locums
		Prosthesis	29.16	34.32	5.16		5.16	
		Special Services	39.06	45.15	6.09		6.09	
		Travel, training and education	15.80	9.28	(6.52)	6.52	0.00	Transport costs of locums
		Travel, training and education - TESL	5.26	6.76	1.49		1.49	
	REPAIRS AND MAINTENANCE	**Total**	**57.52**	**57.00**	**(0.52)**		**(0.52)**	
	DEPRECIATION	**Total**	**141.39**	**141.84**	**0.45**		**0.45**	
	BORROWING COSTS	**Total**	**0.52**	**0.61**	**0.09**		**0.09**	
Revenue	**Total Revenue**		**(360.23)**	**(356.64)**	**3.59**		**3.59**	
	REVENUE	Accommodation	(120.90)	(123.44)	(2.54)		(2.54)	
		DVA	(16.11)	(14.19)	1.92		1.92	
		Facility Fees	(23.92)	(28.40)	(4.48)		(4.48)	
		Grants and Contributions		0.00	0.00		0.00	
		High Cost Drugs - Rev	(57.16)	(56.79)	0.38		0.38	
		MAA	(24.60)	(27.13)	(2.52)		(2.52)	
		Other Revenue	(109.20)	(99.63)	9.57		9.57	
		Prosthesis Income	(8.34)	(7.06)	1.27		1.27	
Net Cost of Services			**2,494.94**	**2,474.12**	**(20.82)**	**55.02**	**34.20**	

Appendix 2 – Examples of innovative virtual care practice

Mental Health First Responders

The Mental Health First Responders (MHFR) is designed to assist emergency services first responders to triage cases involving police or ambulance services where a person may be experiencing mental ill health, to avoid unnecessary transfer to hospital. The service delivers 24/7 virtual mental health triage on mobile devices. MHFR is currently in its expansion phase and will soon be available in 88 towns across the Hunter and New England regions with more than 1400 police and 750 paramedics trained in the virtual program.

The program has a number of benefits for patients, including reduced trauma, home-based support positive experiences and more appropriate care. From a system perspective, it results in reduced presentations to the ED, efficient use of resources, including keeping police and ambulance in the community.

HNE Virtual Kids

Virtual Kids was established in 2021 in response to a high influx of children with respiratory viruses admitted to emergency departments (ED) across the district. It gave families an alternative care pathway to an ED presentation and provided clinical support and reassurance to families to manage their child's care at home.

Since this time the service has expanded to address other appropriate conditions such as gastro-like illnesses. It helps reduce the number of presentations by using video conferencing technology to connect families with a clinical nurse to determine the best care pathway based on each individual's needs. Since its implementation, it has provided care for over 5700 children, reducing ED representation and empowering families across the district, regardless of their geographic location.

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Hunter New England Local Health District

Hunter New England Local Health District spans a large geographic area and is comprised of multiple facilities offering a range of services.

The district has:

- 1 tertiary referral hospital (John Hunter Hospital and John Hunter Childrens Hospital (Rankin Park).
- 4 rural referral hospitals (Armidale, Maitland, Manning (Taree) and Tamworth hospitals).
- 12 district hospitals
- 8 community hospitals
- More than 60 community health services
- 7 inpatient mental health facilities plus community mental health services
- 3 residential aged care services

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