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Submission of the Nepean Blue Mountains Local Health District (NMBLHD) to the Special Commission of Inquiry into Healthcare Funding.

With around 7,000 staff, NBMLHD is responsible for the health and wellbeing of more than 384,000 people living in rural, remote and concentrated suburban areas across the local government areas (LGAs) of Penrith, Hawkesbury, Blue Mountains and Lithgow – almost 9,179 km2. The total population is expected to reach 430,000 by the year 2036. Our staff deliver world-class and innovative health care in five hospitals and nine community health centres. Services are provided to people of all ages, from before birth, throughout child development to chronic and complex conditions, and palliative care. Hawkesbury District Health Service, which includes a hospital and community health centre, is operated by St John of God Health Care, under a public-private partnership with the District. We have a strong and vibrant multicultural community with an estimated 20% of our residents born overseas. The main languages other than English spoken at home in our region are Arabic, Filipino, Hindi, Mandarin and Punjabi.

NBMLHD faces fundamental challenges in service delivery into the future including population growth, particularly in the older age (70+) and younger age (0-14) cohorts; addressing health disadvantage and high rates of poorer health; relatively lower rates of private health insurance; rising costs; attracting a skilled workforce; providing sufficient infrastructure for demand and ensuring safety and quality.

The NBMLHD Aboriginal and Torres Strait Islander population makes up 3.3% of local residents while 22.8% of people were born overseas with 9.8% predominantly from non-English speaking countries i.e., Culturally and Linguistically Diverse. The NBMLHD Aboriginal population is a younger population due to higher fertility rates, higher death rates and lower life expectancy (9.3 years lower in males and 8.5 years lower in females) than NBMLHD Non-Aboriginal population.

NBMLHD is pleased to be able to contribute to the enquiry and its consideration of opportunities for NSW Health to improve the delivery of care to the community. The response is grouped into key themes.

CURRENT FUNDING ARRANGEMENTS

Activity Based Funding (ABF)

There have been significant benefits to the introduction of ABF in the NSW Health System. It has provided much greater transparency to cost, relative efficiency and an ability to benchmark at an increasingly granular level. However, there are several practical issues with the current arrangements.

- There is little direct relationship between funding and activity targets. In addition, activity targets often bear little relevance to the reality of changes in demand.
- ABF has since its inception, often been a retro-fitting of the funding model onto historical budgets with limited addressing of any historical inequities in resource distribution. There has therefore been limited 'money follows the patient' as is the premise of ABF.

- Clinical coders are paid significantly less than other states, and it is generally an under-resourced function delivering less value in comparison. As a result under capture of activity in volume and accuracy is an issue.
- An associated outcome of this is that education of clinicians in clinical documentation has been variable further contributing to the data capture issues.
- The focus and incentives of ABF are on inpatient activity as opposed to outpatient, primary or community care.
- Due to the focus on inpatient activity, ABF provides limited ability to divert resources/ invest in out of hospital capacity, for example virtual care or hospital in the home.
- There is limited ability to invest in locally new innovative models of care in community health/ out of hospital care that are financially sustainable due to the structures of ABF.
- A key consideration for funding of the health system and ABF is the increasing prominence of out of hospital/ primary and community care versus the Federal/ State split of responsibilities. This represents a significant practical impediment to development of services in this area.
- There are significant supplementary funds received by LHDs throughout the financial year that is often outside the ABF funding model. This detracts from the ABF mechanism and complicates funding arrangements.
- A renewed focus on outcomes/ value delivered rather than activity volumes together with a shift to focussing on preventive/ community care would be welcome principles for changes to current arrangements.
- Innovations in the use of for example pooled budgets between health and social care like those used in the NHS could be a useful way to begin integration of services and fund out of hospital capacity.

Funding of The Operating Costs Of Capital Redevelopments & ABF

Use of ABF as a basis for the funding of new redevelopments has been problematic. Typically, hospital redevelopments have significant additional operating costs for a given number of patients. Examples of this include:

- Increased overhead costs such as cleaning due to a bigger floor area,
- Additional building maintenance cost,
- New technology implementation, e.g., robotic pharmacy,
- Additional clinical staff due to the increased size, e.g., contemporary Emergency Departments are often more than double in size and have physically separate areas, e.g., physically separate paediatric or short stay units and,
- Additional clinical staffing costs due to implementation of improved and contemporary models of care often precluded in old infrastructure, e.g., full implementation of an inpatient dementia model of care in purpose-built infrastructure.

It is difficult for all these additional costs to be reflected in ABF funding, particularly as they are not generating additional National Activity Weighted Units (NWAU) upon which LHD funding is based. NBMLHD has a significant financial challenge in sustainably funding the operating costs of its Nepean Hospital redevelopment.

Other funding issues

New services/ initiatives: Often the full value of funding for new services/ initiatives or confirmation of same is received after the commencement of the fiscal year and is often time limited. This leads to delayed implementation and underspends in the first year (due to the practical lead time and/or difficulty in recruitment). In addition, there is often uncertainty of whether funding will continue which leads to further difficulty in recruiting/ retaining staff which further hampers delivery of outcomes.

WORKFORCE

Post the immediate pandemic response phase workforce issues have emerged as one of the key challenges facing the NSW Health System and NBMLHD. Previous long-standing issues specific to the Health System and in broader society have been exacerbated by the pandemic. What follows is some of the key issues and opportunities we see in this area.

NBMLHD (as with other LHDs) struggles to match the private sector salaries for some disciplines/ professions. A key issue is that the public system provides significant training for all disciplines, but it often cannot offer salaries equivalent to those in the private sector.

The current Awards often act as a disincentive to work in the public system given the higher salaries available in the private sector. Allied Health private sector salaries or private nursing agency salaries are good examples of this issue.

These current shortages result in competition between LHDs and other jurisdictions which further drives up costs, increases inequity and adds to the incentive for staff to move out of the public system. Greater coordination in this area to manage the market at a system level (as far as possible) would be beneficial.

In addition, the geographical location of NBMLHD is a limiting factor in attracting candidates. This is particularly true of the regional facilities at Lithgow and Blue Mountains. This leads to an unequal distribution of workforce across NSW with disparities most acutely experienced in rural and regional areas.

Further expansion of the scope of roles and practise of nursing and allied health professions offers potential solutions to these current workforce challenges. New and innovative models of care linked to non-traditional scope of practise for non-medical roles would assist. For example, in the NHS hospital pharmacists prescribe medicines in a range of areas and dieticians in the UK also can practise supplementary prescribing.

More generally recruitment and onboarding timeframes take too long and need to be reduced. Also, there is duplication in administrative processes when staff move between LHDs. Staff typically have to redo documentation despite remaining an employee of NSW Health and this particularly affects clinical front-line staff due to their credentialling and vaccination requirements. The concept of a ‘NSW Health workforce passport’ is welcomed.

A lack of flexible working for front-line staff is also an issue. Examples of flexible working for front-line staff from the NHS UK include electronic team-based rostering, staggered working hours, term-time hours, and compressed working weeks. Genuine flexible working policies for front-line staff would materially improve recruitment and retention rates and staff well-being.

Current Industrial Awards often no longer meet the requirements of the workforce or contribute to contemporary models of care. They are often structured around the traditional 5 day working week and core ‘business hours’ despite the system delivering care ‘24/7’. Services that aid patient discharge, for example allied health staff or pharmacy access are typically not available at weekends.

A key outcome of this is a mismatch in provision of services to when demand occurs. For example, the volume of discharges from public hospitals is traditionally lower at weekends despite unplanned admissions occurring reasonably consistently across the week. Despite this structural mismatch many

senior medical staff work extended hours during the working week, and some can spend significant time in hospitals during periods of on-call.

Like many LHDs, NBMLHD struggles to recruit certain professions/ disciplines key examples of which are 'middle grade' Medical positions for Emergency Medicine, Obstetrics Consultants (to regional facilities) and psychiatrists. This leads to the common use of premium labour, more expense and at times a lower level of care.

A distortion to the labour market for staff in the NSW Health system is the differing Award conditions across jurisdictions. For example, Queensland offers significantly nursing higher salaries and incentives than other states. This is a further incentive for staff to transfer out of NSW Health.

Significantly improved workforce capability in clinical analytics, artificial intelligence, business intelligence and technology in general is also needed given the exponential growth in this area across the economy.

Finally post-COVID the issue of work-life balance and well-being is more prominent in society and the workforce in general. The increasing focus across the system on these issues is welcomed and critical to recruitment and retention of the workforce.

STRATEGIES TO ADDRESS ESCALATING COST, WASTAGE AND EFFICIENCY

There are several areas that could produce productivity gains whilst improving staff and patient experience and potentially making the system safer.

There are many workflow processes that could be streamlined or automated to provide productivity gains and reduce the administration burden on staff. Examples include automation/ digitally enabled HR processes or patient interactions, and use of real-time analytics to automate tasks such as clinical audits or clinical registry data collection. Corporate systems particularly those used by frontline managers to manage workforce are difficult to use and increase the administration burden for managers. The advent of the Single Digital Patient Record (SDPR) is a major step to addressing these issues from a clinical workflow perspective.

The Ministry's 'Time for Care' program which aims to reduce unnecessary administrative tasks and increase staff time for patient care is welcome. An area of acute need are current rostering practices and associated management information systems. In addition, the reform of clinician workflow in using clinical information systems is a major productivity opportunity that will improve staff and patient experience.

Award reform could also make a significant contribution to addressing cost escalation and efficiency through improvement of workforce flexibility and the better matching of system demand and capacity through new ways of working. Medical Award reform and the arrangements for Staff Specialists, Visiting Medical Officers and Junior Medical Officers requires particular attention.

Improvement in reporting to aid financial management is needed. In particular use of analytics and better and easier information provision to management in terms of workforce management would greatly assist (e.g., rostering practises, overtime usage, and leave trends etc). The same is also true if non-salary expense (e.g., visibility of price variance, non-state contract use etc). Financial reporting is traditional and focusses on the outcome not the processes to be managed that influence cost.

The significant numbers of patients who have finished their acute care but remain 'stuck' in public hospitals is a major source of inefficiency and poor patient experience. The recent rise in patients from Residential Aged Care Facilities (RACF) and National Disability Insurance Scheme (NDIS) consumers that remain in hospital beyond their intended discharge date is a significant burden on the public hospital system which has had to act as an option of last resort due to a lack of services/ appropriate accommodation.

Increasing out of hospital care models and innovating with technology in such areas as RACF rapid outreach teams, Virtual Care, hospital diversion models and Hospital In The Home services through a revised funding structure offer potential significant productivity gains whilst improving patient outcomes and experience. As already mentioned, the current ABF model and the Federal/ State division of responsibilities limits progress in this area.

A review of the role of Affiliated Health Organisations (AHOs) in the NSW Health system would potentially offer an opportunity for resource efficiency, reduction of duplication and improved patient experience. A relatively disproportionate amount of time is spent on managing relationships with some AHOs that provide significantly smaller services relative to the size of the LHD.

Improved integration of data assets and clinical systems across acute and primary care offer the potential for significant increases in productivity. Methods of communication and information transfer between GPs, hospital Junior Doctors and hospital Specialists is often disjointed and fragmented. For example, the transfer of discharge information to GPs could be significantly improved. The Lumos initiative is a welcome start in this direction.

The Ministry focus on value-based care is supported. Disinvestment from low value care is a challenging area but one that provides significant potential for improving patient care, patient experience and resource efficiency.

Yours sincerely

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