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HEALTH SERVICES AMENDMENT (SPLITTING OF THE HUNTER NEW ENGLAND HEALTH DISTRICT) BILL 2025

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Hunter New England Local Health District

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1. Introduction

Dear Committee

Since stepping into the role of Chief Executive in 2023, I have been continually inspired by the people who make up the fabric of our health system – our patients, our communities, and the more than 20,000 dedicated staff and volunteers who serve them.

Across Hunter New England Local Health District, our people work tirelessly to deliver high-quality, compassionate care to nearly one million residents in the Hunter, New England, and Lower Mid North Coast regions.

Their commitment and resilience – often in the face of significant challenges – reflect why remaining as one unified district matters.

Every day, I see the difference our integrated system makes. From a resident in Mungindi receiving cardiology testing from a Newcastle-based specialist, to a patient in Narrabri accessing cancer treatment with support via virtual care, to an occupational therapist helping a family in Inverell through our allied health programs – the strength of our District lies in our ability to work as one connected system.

Splitting the district would be disruptive, costly, and ultimately detrimental to the people we serve. It would not solve our most pressing challenge: workforce shortages. This is a nationwide issue affecting all sectors but is felt most acutely in regional and rural areas like the North West of NSW.

Forcing a separation between the Hunter and New England regions would fragment our workforce, duplicate systems, and reduce our flexibility to deploy staff and resources where they're needed most. Rather than improving recruitment, it would create instability and reduce access to care, particularly in the communities already facing the greatest barriers.

Our patients don't need more siloes, and neither should our system operate in them. The current structure allows us to share specialist expertise, invest in innovation, and deliver care as close to home as possible, even amid ongoing health system challenges.

It also ensures financial sustainability. The Hunter region's higher activity and population base effectively subsidises the more complex and costly care required in the New England North West. This model allows us to maintain vital rural health services that would otherwise be unviable. Breaking up the district would not only duplicate costs but also takes away our ability to cross-subsidise in a way that better meets the needs of our communities — metropolitan, regional, and rural.

Importantly, while the District operates as one connected health district, our leadership is distributed. Local general managers and health service managers have genuine decision-making authority – including over recruitment and operations – to ensure services are tailored to their community's needs.

When NSW moved from the Area Health Service model in 2005, our district was formed by uniting the Hunter, New England, and Lower Mid North Coast regions. Unlike most others, it remained intact in 2011 after a strong case was made by staff and the community. The same risks that applied then remain today: fragmentation could disrupt patient care, reduce economies of scale, create communication and IT challenges, and weaken regional partnerships.

Our recent restructure of clinical operations was designed to strengthen leadership and enhance oversight of rural and regional services. The executive director of clinical operations is based in Tamworth, supported by a leadership team who work closely with hospital managers, clinicians, and communities to deliver safe, high-quality care.

While we remain committed to engaging thoughtfully in every review and process, the ongoing debate around a potential split is taking a toll. Our leaders, clinicians, and operational staff are repeatedly called on to justify the benefits of integration, diverting valuable time and energy from

improving services. This narrative risks undermining community confidence in a system that is working hard to deliver better care where it's needed most.

In my time as Chief Executive, I've seen the power of collaboration across our district – the breakthroughs in care, the shared innovation, and the collective focus on delivering better outcomes for patients and families. The information below outlines the benefits of keeping Hunter New England as one District. It's this shared responsibility and purpose that make our system strong and our communities healthier.

For these reasons, I strongly urge the Committee to maintain Hunter New England Local Health District as one unified health district. Our patients, staff, and communities deserve nothing less than a connected, high-performing health system that puts their needs first.

Sincerely,

Tracey McCosker, PSM

Chief Executive

Hunter New England Local Health District

2. Patient care and safety

2.1 The value of a centralised health district

Hunter New England Local Health District operates as an integrated network, ensuring patients across a vast geographical area – from regional hubs to remote local communities - can access safe, timely, and coordinated care. A map of the District's facilities is provided at Appendix 1.

The current model helps patients move through the system, supported by structured referral pathways and shared clinical services across emergency care, surgery, maternity, paediatrics, cancer, chronic disease management, Aboriginal health, and mental health.

These services are enabled by a central governance model, inter-facility collaboration, and the capacity to share resources and expertise where required. This system is particularly critical for the district's most vulnerable populations: those living in rural and remote areas, patients with complex needs, and those requiring specialist input not available locally.

2.2 Risks of fragmentation

Splitting the District would introduce artificial boundaries that would:

- Disrupt referral and escalation pathways
- Delay access to specialist and other services
- Duplicate clinical governance structures and virtual care
- Undermine workforce flexibility and coordinated clinical services planning

Such changes would result in significant fragmentation, reducing the quality and consistency of care while increasing logistical hurdles including travel, cost, and risk for patients.

2.3 Virtual and emergency care

Virtual care services are critical to maintaining service equity across the District's vast geographic region. It ensures access to specialist advice and medical coverage in communities that cannot sustain full-time local specialists, for example:

- **My Emergency Doctor**, used across 29 emergency departments in the District, enables 24/7 medical coverage at smaller facilities where a doctor would be otherwise unavailable, reducing unnecessary transfers and supporting local nurses.
- **Telehealth-based stroke clinics and virtual stroke outpatient** clinics connect remote communities with specialists, helping to avoid critical treatment delays.
- **John Hunter Hospital's** emergency retrieval service acts as a mobile intensive care unit, with senior clinicians supporting inter-facility transfers district-wide. From 2020 to 2024, this retrieval services provided 213 transfers and over 1000 consultations.

A split district would sever these integrated services, particularly affecting the New England North West region. Further, fragmentation may reduce the timeliness of access to John Hunter Hospital's retrieval teams and specialist trauma consultation, which could impact outcomes for patients requiring urgent intervention.

Establishing equivalent services independently would take years, require substantial investment, and result in a significant loss of productivity – particularly concerning in an environment where attracting and retaining specialist health staff is already a major challenge.

Case study: ADHD shared-care model

A new ADHD clinic in Newcastle delivers specialist care to children across the District — particularly those in rural areas — via virtual consultations and shared management with General Practitioners that would otherwise be unavailable due to a lack of specialists in the area.

As of early 2025, the service supports over 70 children in the New England North West region, with 16 general practices engaged in shared-care arrangements.

This hybrid model reduces hospital waitlists and empowers primary care, but depends on a district-wide approach to coordination, workforce, and funding.

2.4 Risks to clinical quality and safety

The district's comprehensive clinical governance framework ensures district-wide patient safety monitoring, incident response, and continuous improvement. This includes oversight of adverse events, support from specialised clinical leaders, the sharing of best practices, a coordinated response to emergency risks, and a networked system for those impacted.

Splitting the district would necessitate the duplication of governance structures, slowing response times for critical incidents and diminishing the overall quality of patient care.

Case study: Hospital HealthPathways

A clinician-focused platform the district has developed in partnership with the Primary Health Network and Central Coast Local Health District, Hospital HealthPathways provides evidence-based clinical pathways and referral guidance.

Originally targeting junior doctors, it is now a trusted resource district-wide, with usage doubling between 2021 and 2023. The program's success reflects the power of coordinated implementation and shared clinical leadership - both of which would be undermined by a fractured district model.

2.5 Specialist and outreach services

Hunter New England Local Health District provides specialist and outreach services including neurosurgery, interventional neuroradiology, vascular surgery, intensive care, termination of pregnancy, trans and gender services, infectious disease, and advanced cardiac procedures.

The delivery of many of these services relies on the scale, infrastructure, and clinical leadership of central facilities such as John Hunter and John Hunter Children's Hospital, as well as coordinated planning across the district.

Outreach programs and virtual services extend specialist care to rural and remote communities through structured agreements, shared workforce models, and digital technology. Examples include:

- Cardiology clinics for Aboriginal patients
- Oncology outreach services in regional centres
- Virtual stroke outpatient clinics
- Telehealth-based psychiatric care
- High-risk maternity support via virtual and face-to-face consultations
- Children's rehab clinics which have treated over 100 patients on average each year for conditions such as cerebral palsy movement disorder, paediatric brain injury, and spinal urodynamics.

This district-wide model ensures access to complex and high-risk care - particularly for vulnerable populations – by supporting integrated outreach programs and shared clinical and governance structures. Fragmenting the district would disrupt these models, delaying interventions and requiring years to re-establish effective systems.

Whole-of-district delivery of services like mental health, drug and alcohol, maternity and infectious diseases allows for the dynamic allocation of beds, staff and resources. A split would reduce flexibility, create inconsistences in service access, and increase delays and clinical risks – especially for patients in regional and remote areas.

Case study: Diabetes Alliance Program Plus (DAP+)

A joint initiative between the District , the Primary Health Network, and Hunter Medical Research Institute, DAP+ program addresses high rates of undiagnosed and unmanaged diabetes, particularly in rural areas, by providing multidisciplinary care, local provider training, and patient education.

Led by specialist clinicians based at John Hunter Hospital, the program will also introduce a medibus to deliver mobile diabetes care to rural and remote communities in the second half of 2025, with the potential to be adapted for other chronic and complex conditions.

2.6 Community voice and local accountability

Local Health Committees (LHCs) play a vital role in ensuring community input into local health services. The District has reinvested in this model, with the *Strengthening Local Health Committees* report (endorsed August 2024) outlining more than 70 recommendations for improving engagement, governance, and sustainability. These efforts will provide a foundation to rebuild trust with local communities and ensure transparency in service planning. A split district would risk losing this consistency of engagement and the shared identity that supports strong partnerships with communities.

3. Financial and corporate governance

3.1 Operational duplication and financial impact

Establishing a separate New England North West Local Health District would result in significant financial and operational inefficiencies.

The District incurs approximately $201 million annually in operational, governance, and administrative costs. Creating a new local health district would require either duplicating or redistributing these functions, with an additional estimated a recurrent $111 million required. This would fragment existing systems, reduce economies of scale, and potentially compromise the quality and continuity of patient care.

The District's funding model, which combines Activity Based Funding (ABF) with allocations for small and rural facilities, is based on historical data and often does not reflect actual service costs. The district's diverse geography means larger metropolitan hospitals subsidise higher-cost rural sites like Tamworth and Manning, which face greater staffing and logistical challenges. A district split would disrupt this balance and increase financial strain across both urban and regional services.

3.2 Impacts on corporate governance

A centralised structure enables the District to ensure consistent policy implementation, streamlined reporting, and robust corporate governance across all facilities. Splitting the District risks creating variation in compliance, oversight, and risk management, weakening the ability to identify and respond to safety concerns in a timely manner, and undermining system-wide accountability.

3.3 Technology, digital systems, and cost duplication

The District is in the final stages of a comprehensive five-year digital transformation, which includes network upgrades, expanded virtual care, and improved connectivity.

Innovations such as the iPharmacy platform and the forthcoming Single Digital Patient Record (SDPR) are improving clinical decision-making and patient outcomes. Dividing the district would require reconfiguration or duplication of these digital systems, including electronic medical records (eMR), imaging repositories, and reporting infrastructure, along with the people managing these, introducing additional costs, longer timeframes, and raising risks related to data fragmentation.

3.4 Infrastructure, planning, and clinical service integration

While major infrastructure projects such as the $835 million John Hunter Health and Innovation Precinct - forming part of the more than $1.8 billion capital investment across the District - would

continue irrespective of organisational structure, dividing the district would complicate planning, governance, and the integration of clinical services.

Strategic frameworks and clinical services planning may require reassessment and redevelopment to align with a new operational context.

Case study: Sustainability programs

The District's sustainability initiatives, such as the *Out-fits to Fit-outs* uniform recycling project and the *Gloves Off!* program, have delivered measurable cost savings and waste reductions.

For example, reducing unnecessary glove use has saved the District $300,000 annually, allowing funds to be redirected into frontline care, and significantly reducing landfill waste.

These programs benefit from centralised coordination and strategic oversight. A split would require the duplication of governance structures and could risk the implementation of environmental initiatives across multiple jurisdictions.

4. Workforce

4.1 Recruitment and retention challenges

Hunted New England Local Health District faces ongoing difficulties in attracting and retaining skilled healthcare workers, particularly in rural areas. These challenges are driven by national workforce shortages, shifting work preferences (e.g. increased demand for part-time roles), uncompetitive NSW Award conditions compared to other states, delays in overseas recruitment, and a preference among staff for metropolitan locations.

Recruitment is locally managed with support from the People and Culture team, but outcomes are limited by these broader structural issues. Creating a separate New England North West district would not resolve these challenges and may exacerbate them by removing immediate access to teaching hospitals and senior clinicians who provide essential training, supervision, and support to new graduates and professional development for ongoing sustainability of care in outreach centres or clinics.

The District has recently achieved success in attracting specialists to several regional and rural facilities, largely due to its strong connection with John Hunter and John Hunter Children's hospitals. In 2024, 13 doctors commenced roles at Tamworth Hospital across a range of specialties, including orthopaedics, paediatrics, oncology, neurology, haematology, emergency medicine, aesthetics, as well as obstetrics and gynaecology.

4.2 Flexible workforce programs at risk

A centralised district structure has enabled some flexibility across regional and rural areas, which is critical for service continuity.

Facilities across the New England North West, including major hospitals such as Tamworth and Armidale, as well as smaller hospitals and multi-purpose services, continue to depend on short-term staffing solutions, such as the district's rural reliever pool, due to the persistent difficulty in securing permanent staff.

- **Allied health:** The Allied Health Rural Reliever Program delivers over 10,000 hours of support each year through five full-time equivalent positions, ensuring continued service delivery during staff leave across the New England North-West. Currently, 60% of relievers travel from outside the proposed new district boundaries due to difficulties recruiting locally. If the district were to split, these staff would no longer be able to provide coverage, significantly reducing service availability. Similarly, the *Early Career Rural Generalist Program* - known for offering diverse rural allied health rotations and achieving a 75% retention rate - would be affected. A split would limit rotation opportunities, decreasing both retention and rural service access.
- **Nursing and midwifery:** The *Nursing and Midwifery Rural Reliever Program* uses Newcastle and Maitland-based nurses to support rural sites as needed. As of February 2025, 184 nurses are part of the program, 86 of whom are emergency trained. Weekly, around 60–70 reliever nurses

are deployed. Detaching the program from the broader district would undermine rural coverage, leading to further service closures.

4.3 Incentives and strategic workforce planning

The District supports recruitment and retention through centralised workforce planning, streamlined processes, and career development pathways. A split would fragment these efforts and diminish the attractiveness of many clinical and corporate roles.

The *Rural Health Workforce Incentive Scheme (RHWIS)* supports positions classified as hard to fill or critical to service continuity. As of February 2025, the District had a total of:

- 1,773 hard-to-fill positions (1,347 FTE)
- 1,243 critical positions (900 FTE)
- 67% of incentivised roles are located in the New England North West region
- $12.17 million spent YTD, projected to reach $20.17 million for the 24/25 financial year

The District's strategic planning also supports clinical networks across urgent care, procedural services, maternity, Aboriginal health, and cancer services. Duplication of these functions in a split would introduce inefficiencies and delay initiatives.

4.4 Education, training, and clinical supervision

The current Hunter New England Local Health District structure enables comprehensive clinical supervision and training pathways that would be significantly disrupted if the district were split. The District is the only one in NSW that enables clinicians to train in a metropolitan, regional, and rural facility.

- **Junior medical officers:** The District offers a two-year rotation program, a dedicated council, and extensive wellbeing and development support. In 2025, 69% of interns graduated from the local program, up from below 50% in 2022. A split would significantly restrict rotations and career profession into New England North West roles, as the region does not have the depth of staff specialists required to support junior medical officer training, ultimately weakening workforce pipelines.
- **International medical graduates (IMG):** The district supports IMG integration through orientation, cultural induction, and the Workplace Based Assessment (WBA) pathway. In the past year, the District has conducted 45 assessments across multiple metropolitan and regional facilities including John Hunter, Maitland, Tamworth, and Manning hospitals. The program has a 99% pass rate, is regarded as a national model, and retains 70% of graduates within the district as employees. A split would limit access to assessment and supervision opportunities for IMGs in rural areas, undermining workforce sustainability.
- **Specialist training and accreditation:** The District provides structured training pathways through John Hunter Hospital, enabling medical rotations without additional travel. If separated, New England-based clinicians may be forced to travel to Sydney for accreditation, affecting lifestyle, retention, and workforce supply.

Case study: Transition to midwifery practice

Delivered through Charles Darwin University in partnership with seven participating hospitals across the District, the rural midwifery pathway offers registered nurses a postgraduate diploma of midwifery with a specific rural focus. There is good retention, as approximately 75% of all graduates remain working in rural and regional facilities, with many transitioning to education or leadership positions.

5. Aboriginal health

5.1 Culturally safe care and service delivery

Hunter New England Local Health District delivers culturally safe care through strong partnerships with Aboriginal Medical Services (AMSs), the Primary Health Network (PHN), and rural general practitioners. Its networked model enables outreach clinics in regional and remote communities, reducing barriers to care and addressing health disparities. Splitting the District risks fragmenting this model, weakening leadership, governance, and workforce coordination, and compromising cultural safety and access for Aboriginal communities.

5.2 Outreach and specialist services

The District operates several outreach programs that deliver care in partnership with AMSs. Notable examples include:

- *Integrated Chronic Care for Aboriginal People*: A team, including a Newcastle-based physician, provides chronic disease management directly in communities.
- *Little Ears, Deadly Care:* Improves access to Ear, Nose, and Throat (ENT) care for Aboriginal children, reducing the need for hospital visits and long-distance travel. A multidisciplinary team of clinicians including ENTs, GPs, audiologists, and respiratory specialists, nurses and Aboriginal Health Practitioners has supported 197 number of patients since its inception.

These programs rely on coordinated governance and shared resources. Division of the District could disrupt these arrangements, leading to reduced access and service gaps across the New England and North West regions.

Case study: Healthy Deadly Feet

Established in 2019, *Healthy Deadly Feet* addresses high rates of foot-related complications among Aboriginal people. The program provides community outreach, cultural navigation, and podiatry services. Since launch, podiatry attendance has increased by 150%, referrals by 68%, and major amputations have declined. The program also reduced hospital stay durations for diabetes-related foot issues at Tamworth Hospital and received strong patient feedback.

5.3 Workforce development and training

The District plays a central role in developing Aboriginal Health Workers and Practitioners through supervised clinical placements and rotational opportunities across regional and rural sites. John Hunter Hospital's tertiary status provides a training environment that supports skill development and practice expansion. A split would reduce access to structured training, intensify workforce shortages, and limit culturally competent care delivery.

The Aboriginal Health Unit (AHU) oversees workforce governance, recruitment, and professional development. Fragmentation of governance would weaken these efforts and reduce the ability to attract and retain Aboriginal staff, particularly in leadership roles.

5.4 Governance and advocacy

A centralised structure amplifies Aboriginal health advocacy through coordinated efforts led by the district's Aboriginal Health Unit. This includes active engagement with the Primary Health Network to influence funding allocations and policy decisions. Smaller or separated services may lack capacity for effective advocacy, placing already under-resourced regions at a disadvantage.

The District's cultural governance network ensures accountability and alignment with strategic objectives, supporting health outcomes for approximately 90,000 Aboriginal and Torres Strait Islander people living and working in our community, and over 1,000 Aboriginal staff. Dividing the District would dilute oversight, reduce consistency, and hinder progress in achieving closing the gap outcomes.

6. Research and innovation

6.1 Scale and funding advantage

The geographic breadth of Hunter New England Local Health District, spanning metropolitan, regional, and rural areas, provides access to a diverse population and broad clinical settings. This integrated structure is a critical enabler of large-scale research, giving the district a competitive edge in securing state and federal research funding.

A structural split would compromise this advantage. A standalone Hunter district would face intensified competition from major metropolitan centres such as Sydney, Melbourne, and Brisbane, without the scale or infrastructure to compete effectively. Loss of connection to regional populations would reduce eligibility for funding focused on rural and remote health priorities.

6.2 Impact on innovation capacity

The proposed expansion of the John Hunter Health and Innovation Precinct depends on whole-of-district representation to reflect regional health challenges in research and funding applications. Fragmentation would limit its strategic scope and reduce investment potential.

District-wide innovation projects depend on centralised governance, shared resources, and cross-regional collaboration. Separation would introduce operational and financial barriers, including duplicated infrastructure and inconsistent standards, rendering these projects slower to implement, cost-prohibitive, or unviable.

Furthermore, the District's ability to attract industry-led research and innovation would be significantly compromised. Emerging fields such as point-of-care technologies and telehealth rely on cohesive, integrated partnerships to support trials and scale new models of care. A divided district would lack the critical mass, leadership, and collaborative ecosystem needed to meet industry expectations, reducing commercial interest and investment in the region.

6.3 Risk to current and emerging projects

Ongoing research initiatives are highly integrated across the District and would be directly affected by a split. Programs focused on telehealth, Aboriginal models of care, medibus outreach, nurse-led innovation, and outreach services would lose cohesion and scale, risking delays, funding losses, or discontinuation. Communities in the New England and North West regions would be particularly affected, with reduced access to innovations developed through district-wide collaboration.

6.4 University and industry partnerships

The District's collaborative arrangements with the University of Newcastle, the University of New England, and Hunter Medical Research Institute (HMRI) form the foundation of its research and innovation ecosystem. Regional services benefit from a centralised innovation and research unit with strong, established links with these organisations through John Hunter Hospital.

This integrated model allows regional areas to tap into expertise and infrastructure that would not be feasible on a smaller scale. A split would weaken these connections, requiring significant restructuring and reducing research capacity and clinical training opportunities across all clinical professions.

The Joint Medical Program (JMP), which trains medical students for careers in regional settings, would also be at risk. Disruption to clinical placements, supervision, and health service collaboration would reduce opportunities for medical training and weaken the pipeline of future regional healthcare professionals.

Private sector investment in clinical trials and emerging health technologies could also decline. Fragmentation and perceived instability may deter commercial partners, making both newly formed local health districts less attractive for research collaboration and innovation.

Appendix 1 – Map of Hunter New England Local Health District Facilities