Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At the Wagga Wagga Court House,
Wagga Wagga, New South Wales

Tuesday, 19 March 2024 at 10.00am

(Day 012)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**

Also present:

Mr Hilbert Chiu with Mr Christopher Chiam for NSW Health

THE COMMISSIONER: Good morning again.

Yes, Dr Waterhouse?

DR WATERHOUSE: I call Robyn Manzie.

<ROBYN HILARY MANZIE, sworn: [10am]

THE COMMISSIONER: Thank you Dr Waterhouse will ask you some questions.

<EXAMINATION BY DR WATERHOUSE:

DR WATERHOUSE: Q. Good morning, Ms Manzie, could you please state your full name?
A. Yes. Robyn Hilary Manzie.

Q. And you are the independent chair of the Murrumbidgee Mental Health and Drug and Alcohol Alliance?
A. That's correct, yes.

Q. Can you please outline your experience prior to your appointment to that position?
A. Okay. I had a 30-year - 33-year career working in health, in mental health and drug and alcohol, from a clinician through to the last few years being the director for the Murrumbidgee LHD.

Q. And as a clinician, I understand you were a social welfare worker?
A. That's correct, yes.

Q. Can you describe a little bit about what that involves?
A. The social welfare role?

Q. That role, yes.
A. As a clinician, I worked in drug and alcohol, so it was seeing clients or consumers, working with them on their issues to improve their lives.

Q. And how long were you the director of the district service for?
A. Eleven years.

Q. When did you become the chair of the group that you are now - the alliance?

A. Yes, January last year, I retired from the local health district in December, which meant I could then be an independent chair of the alliance. They were looking for a new chair and I volunteered to take it on.

Q. I understand that the alliance has been operating since 2015; is that correct?
A. That's correct, yes.

Q. Why was it formed?
A. The Murrumbidgee Local Health District did a mental health drug and alcohol strategic planning process, and one of the gaps identified was some governance system over all the different providers of mental health, drug and alcohol services, so it made a recommendation about trying to establish some connection between all the providers and the alliance grew out of that.

Q. So it was a recommendation of the district?
A. Yes.

Q. And is it, to your knowledge, a unique model? Is it --
A. To my knowledge, it is, yes.

Q. So was it modelled on any other sort of arrangement that's happening elsewhere?
A. No. It was - we had relationships with other providers, like the primary health network funded providers, non-government organisations, but we wanted to enhance those relationships.

So we started off meeting to talk about how we might progress that, and the number one priority for all of the players involved at the time was service integration, because that's very confusing for the community and the consumer, where - do you go here or do you go there? Where do you go for what? And it just grew out of that. We work collaboratively on what's some solutions to service integration and we've just kept going, and that's still our number one priority.

Q. How is the alliance funded?
A. Sorry?

Q. How is the alliance funded?
A. It's actually not funded. We all participate on

a voluntary basis. At a period of time, we realised that if we wanted consumers to sit on our - in our work, to participate in our work, we had to pay them for their time, so we started asking each of the members for a $1,000 annual fee and that funds primarily consumer participation.

We have sought funding for particular projects and then one of the organisations within the membership will take on the lead role. So for some, that's the LHD, for some, that's the primary health network, and whoever is the lead employs the person who is working on the project. But the alliance itself is self-funded through contributions annually.

Q. I understand that there are 20 members, roughly 20 members at the moment; is that right?
A. Yes, yes.

Q. Are they all health service delivery type entities?
A. They are health and health support services, so there is a lot of non-government organisations who provide non-clinical support to people with mental health and drug and alcohol problems. So the bulk of our members are actually the NGO sector. We've also got some ancillary members who don't directly provide mental health or drug and alcohol services, but a lot of their services are provided to people with those problems - for example, the Department of Communities and Justice is an ancillary member.

Q. And is that within the 20 or is that --
A. That's within the 20, yes.

Q. So the main sort of two members, are they the district and the primary health network?
A. Well, the three biggest organisations are those two and DCJ, but we don't talk in terms of any organisation being more important than the others. So one of our principles from the beginning has been that everyone in the room is equal, so the smallest NGO has the same amount of power in the room that the biggest organisation has, and we're really clear about that and it's one of the things that keeps people engaged.

Q. Did you used to attend the alliance meetings as part of your role at the --
A. Yes, yes.

Q. Now, some of the NGOs, as I understand it, may seek funding from the same sources --
A. Yes.

Q. -- which could put them in competition; is that right - they could be competing for some funding?
A. They can be - sorry, that sun is very bright.

Q. I'm sorry about that. It will disappear --
A. I'll wiggle around. They do, but that never comes into the room in the alliance. The submissions that they put for funding happen through a very separate process and it's not - it doesn't come into the room.

Q. So there is no sort of tension that arises that you have to manage as the independent chair?
A. Initially there were concerns from some of the NGOs, but they were all committed to the process and to the aim of service integration, so we just worked our way through it, yes.

THE COMMISSIONER: Q. Can I just ask, I'm looking at paragraph 2 of your outline, which mentions the mental health drug and alcohol review in 2015 that led to the alliance being formed. Was that review - first of all, do you know what - the reason that the review was done?
A. We regularly went through strategic planning processes to identify gaps in services and what our priorities were and plan ahead. So it was just part of that normal cyclic --

Q. And mental health and drug and alcohol assistance was something that was seen as a gap at the time?
A. No. All of the services were kind of cycling through strategic planning processes and it was just a normal --

Q. Did the review result in a written document?
A. Yes, it did.

Q. And that's available somewhere?
A. Yes.

THE COMMISSIONER: Thank you.

DR WATERHOUSE: Q. So I understand the alliance has three working groups?

A. Yes.

Q. Can you tell us about the community information strategy group?
A. Yes. We understood that communities get very confused about services, and no matter how much you promote a service by whatever means, people don't take that information in until they actually need a service, and then they don't know where to go. So that has been a perennial problem. So that group is looking at how do we get information out into the community on a regular basis, that there are multiple services out there that - so, between us, we provide A to Z - and this is who to contact for what.

We have an online website through the primary health network called "MapMyRecovery", and all of the alliance providers are active on that website to promote their services. So we can say to people, "Go to MapMyRecovery and you'll find what's available there."

Q. Have you had feedback from the consumers as to whether or not it's helped them navigate their journey?
A. We get feedback from communities when they don't know and we respond to that. We were regularly hearing from the Griffith community that they thought they had no services, so we did a four-page spread in the local print media of alliance services, and we stopped getting those comments that, "We don't have any services", so I think it kind of hit the mark without any active measure that we had hit the mark.

THE COMMISSIONER: Q. Can I just ask, Ms Manzie, is that sun uncomfortable in your eyes?
A. Yes, it is.

Q. I think we can have you, and we should do this for the morning sessions - where Erica was just sitting, there is a microphone.

It might be more comfortable for the witness to give her evidence over there rather than sitting in the blazing sun.

Would you like to move over there, I think it might be more comfortable for you.
A. Thank you. Thank you.

DR WATERHOUSE: Q. So with the information strategy, does that reach out to all of the smaller facilities across the district?
A. The alliance is working towards that. They are working on a campaign for Tumut at the moment. There has been a bit of work done around Young, but that's - there needs to be more work there.

There is a group in Deniliquin that the alliance has supported called the mental health awareness group, and they've been very, very active in Deniliquin. So they've actually got posters all around town about where to find mental health, drug and alcohol services, so the alliance supports that work, participates in some of what they do, yeah.

Q. And where there are towns that may not have a service, can they reach in to, say, Griffith or Deniliquin or Wagga?
A. Yeah, most of the services work on an outreach basis as well, not just in the centre of Griffith. They will actually travel out to the smaller towns.

Q. The addressing stigma working group, can you tell me, how does that operate? What does that do?
A. Yes, at the moment, it's been focusing on language, language can be incredibly stigmatising and disadvantage people, so it's promoting positive language around mental health and drug and alcohol use. So starting with their own staff, because in the conversation in the tearoom you will hear language that is everyday use but it's actually still stigmatising. So the focus at the moment is on the members and their staff to work with them to use positive language around mental health and drug and alcohol issues.

Further down the track, we'll start to move towards media, other avenues, to start to challenge some of the language that's used there.

Q. And is this a stigma that you're looking at primarily around patients or consumers?
A. We're focusing on consumers, but I guess in my career I have seen that stigma extend to staff who provide services to people with mental health and drug and alcohol problems. And when I say "staff", that goes as far as senior clinicians like psychiatrists. I have actually seen them stigmatised because of the field that they work in.

THE COMMISSIONER: Q. What do you mean precisely by "stigmatised"?
A. It can be not valuing the work they do. It can be challenging. It can be, "Why can't you come and take this person away so I don't have to deal with them anymore?" It's a whole range of things. But staff are seen as, sometimes, less than other clinicians, yes.

DR WATERHOUSE: Q. The third priority group - sorry, the third working group, I understand, is addressing priority groups in the community?
A. Yes.

Q. Can you tell us a bit about what their work is focusing on?
A. Their work to date has been identifying which priority groups to focus on, because there's 100 out there that you could focus on and achieve nothing. So it reached a point where the agreed primary priority groups were First Nations people and people with dual diagnosis, if you like, where they have a mental health or drug and alcohol problem, or both, and another health issue, like a disability, et cetera. So they're the two priority groups.

That's the point they are at now. So going forward, it will be working with alliance members to do a better job of providing our services to those two target groups.

Q. I want to ask you about some of the work that the alliance has been doing regarding suicide?
A. Mmm-hmm.

Q. For that, I think it would help if we look at the context. I'm just going to bring a document up on the screen, that you will be able to see, and it is probably a document with which you are familiar. It is C.23.7, which is [SCI.0004.0159.0001].

THE COMMISSIONER: Did you say 23.7?

DR WATERHOUSE: That's right.

Q. You've been handed a copy of that so that you can see it a bit more clearly. I think we will also shrink it so that we're just focused on the boxes rather than the pyramid, if we can do that. Are we able to home in on the

boxes?

THE COMMISSIONER: The witness has it in her hands, I think.

DR WATERHOUSE: That's okay, let's just take it back to being on the screen.

THE COMMISSIONER: Why don't you keep going while we do this?

DR WATERHOUSE: Q. So what you can see from the page there - and hopefully, most people will be able to see it - the top right box says that there are, on average, 42 suicide deaths per year in the Murrumbidgee Local Health District. I just draw attention to the fact that this is 2015 to 2019 data, so I appreciate that it's actually a little old. But, at that stage, at least, there were 42 deaths per year, on average, with 35 being male.

And if we move across to two boxes across, it is the third leading cause of death in people aged zero to 74. The middle box there indicates 83 per cent of these deaths occur in males, and the bottom right box indicates that 8 per cent of these death were in Aboriginal people, which, as I understand it, is an overrepresentation relative to the proportion of the population. In very fine print there, it says in the first line:

> *Suicide rates in the Murrumbidgee [Local Health District] have been significantly higher than NSW rates from 2015 to 2018.*

So taking that all into account, is that a reason why the alliance has been focused on a number of initiatives to deal with suicide prevention?
A. It is. And it's also, they're avoidable deaths and every one is a tragedy, and for each death, there are a whole heap of people around them and communities that are bereaved. So one death actually translates into a lot of grief and trauma. Because we work in the field, we're exposed to that, so it's front of mind all the time. Yes.

Q. Can you tell the Inquiry about the suicide prevention collaborative that the alliance is running?
A. Yes. It has a number of components. There is a broader group that brings in some external people, like

national headspace, et cetera, and it's kind of an advisory body, so it looks at what we might be doing and how we might do it better.

Then, there are two local initiatives. One is those who provide direct services around suicide prevention, so it's the LHD, the primary health network, because they fund some services, and Wellways, which is the NGO provider, and that's very on the ground, monthly, "How is it going, who's doing what, what else can we do?"

Then there's a local response group, which is again those three parties plus police and ambulance, and when there is - particularly if you get a couple of suicides that look similar or one that's particularly traumatic in a town, that group will immediately hold a meeting and talk about what's happening, who is doing what, and kind of pooling that into what else might we do, and that conversation led to the STOP campaign, which is --

Q. I might come back to that in a moment, if that's okay.
A. Okay, yes.

Q. So with the local response group, that's a meeting of the members of that group. Do they meet with other people in the community to try and --
A. At times. There were a series of deaths of young people associated with schools, so education were involved at that stage, national headspace were involved. So it's an as-needed, bringing other groups in to participate.

Q. You mentioned Wellways.
A. Yes.

Q. What does that group actually do?
A. They provide several services. One is around community supports. So where a community is struggling, because there has been a suicide or more than one suicide, they will get very active in that community and hold meetings and functions, and that's around checking how the community is going, making sure they know how to contact services if they know someone who needs help, making sure they know how to respond to someone who is feeling suicidal.

They also have an after-suicide support service. So if someone has had a suicidal crisis or suicide attempt,

they will provide one-on-one non-clinical support for whatever period of time that person needs to help them get back on track in their lives, and they also provide after-suicide support for families, loved ones of people who've died by suicide.

Q. So when you say they are "non-clinical", do they connect in with the clinical team to manage --
A. Yes, very much so.

Q. You mentioned the STOP campaign.
A. Yes.

Q. Can you describe what that is?
A. Yes. We were having conversations about how do we reach people who are at the point of making a decision, because all of our feedback from consumers, who had been in that point and attempted or thought about, was, once they make the decision, the decision's made. So trying to - how do we reach people at that point where they're thinking about, "Is this an option for me. " So it was from working with consumers, the message is STOP - stop; take a breath; one thing at a time; pick up the phone. So that's the simple message for someone who's at that decision-making point.

So then it's coasters and posters and all sorts of messages, some videos, et cetera, where they - the group - are putting through hotels, all sorts of public venues. The aim is the back of every toilet door will have a STOP poster, so that anyone who's at that point, has a reasonable chance of seeing a message that might make them rethink their decision, yes

Q. To be clear, is STOP an acronym that stands for --
A. Yeah.

Q. So it's stop --
A. Take a breath; one thing at a time; pick up the phone. Yeah.

Q. Have you had feedback from people that have seen those messages and feel that it has made a difference to them?
A. I haven't personally, but the agencies that are involved feel like it's well received. Certainly hotels, et cetera, are really keen to have the resources and make them readily available to their patrons.

Q. I realise that you don't have the data at your fingertips, but do you know if there is evidence that there has been a decrease in suicides relative to those high rates we were looking at before?
A. Yes - the first point I'd make is that Murrumbidgee is not a standout, rurally. Rural suicide rates are higher than metropolitan, and Murrumbidgee is part of that.

At the time I retired, we were looking at the data every three months, we get it from NSW Health, and we had been told through the pandemic to expect higher rates of suicide, and we didn't see that. We didn't see a reduction but we did not see an increase. So we bucked the expected trend in that there weren't increases, but at that stage, we weren't seeing a decrease.

Q. I understand that you're also setting up as part of the alliance a lived experience network?
A. Yeah.

Q. Can you explain what that is and its purpose?
A. Yeah. One of the things in mental health is very strong consumer participation approach, that if we don't engage with consumers and their carers and get their advice on what services will work, then we're not going to have the most effective services we can.

So bigger organisations can kind of manage that to recruit a network and work with them themselves, but the alliance has got a number of small providers, so we came up with the idea of having an alliance network whereby all of the members can access this lived experience network, and that might be feedback on a policy or a strategic plan or it might be, "We've got this problem. Can you help us solve it?" So the network will be available to all of the alliance members. So it'll be consumers and carers. Yes.

Q. How will they be selected?
A. Self-select. We don't screen people out. We clearly look for people who want to contribute to the field. Occasionally, you'll get someone who has had a bad experience and wants to pursue that, but the alliance lived experience network won't be the venue for them to do that. They need to deal with the individual organisation. So this is people who've got an experience that they want to share to help us deliver better services.

Q. How big do you envisage it being in terms of how many members?
A. We're not putting a limit on it. We're looking at an online app where people can have as many as you like, can actually get on that and make a comment on a policy or whatever. From that, they might choose to get involved in working groups, so we can say "We've got this working group looking at" - blah - "who would like to come and join us?" So there would be multiple levels of participation.

Q. You mentioned an app, and I understand that the alliance has actually been developing a shared care plan app. Can you tell us a bit about that, please?
A. Yep. It's called "Journey", and it was one of our very early initiatives. When we did a clinical service redesign looking at service integration, what we heard regularly from consumers and carers was that they had to tell their story multiple times to different agencies and they had multiple care plans that didn't correlate to each other, and we developed the idea that some way of sharing a common care plan would be a great way to overcome both of those things. Then we got an opportunity, with an IT company, to start to develop that app. So it's controlled by the consumer, sits on their app. They control who has access to it.

Q. Where is the development of their app up to?
A. Yeah, it's stalled at the moment with - we no longer have a relationship with the developer, so we're looking at how the alliance itself can actually take over management of that app and pay the licence fees, et cetera. So we're doing some work at the moment to figure out how to do that.

Q. So does the alliance own the app?
A. The intellectual property belongs to the alliance. It was developed through alliance meetings, which included a lot of consumers. There were test runs with consumers to see if they liked the way it worked. Yes.

Q. So just to be clear, it's not actually available at this stage?
A. Not at the moment. It was - we did launch it but there were some glitches in the technology which we haven't been able to get resolved, so that's --

THE COMMISSIONER: Q. How much does this sort of thing

cost?
A. Part of it was funded by NSW Health and I couldn't put a figure on it. So part of it was also the company putting in time, because they wanted to be part of this, yep.

DR WATERHOUSE: Q. So is there a plan going forward to be able to relaunch this, for want of a better way of describing it?
A. That's what we want to do, yep. We're just working through the process of how would we do that.

Q. And you have other people assisting to sort the glitches out?
A. We will probably look to engage an IT company that can actually do that for us. So the alliance will have to fund that.

Q. So in progressing its initiatives, the alliance might encounter barriers. What sorts of barriers have you experienced?
A. I guess amongst the alliance members, they can clearly see the value in knowing what the consumer's goals are and how their care plan addresses those goals, and the LHD is doing this with the consumer, and that NGO is doing that. So the consumer can share all of that information.

Getting parts of health to understand the value of sharing a care plan across agencies - not just within NSW Health - is a bit of a challenge. Yeah.

Q. Can you expand on that?
A. A lot of concerns about confidentiality, which we did work through in the process, which is why the consumer has control over who looks at it. It doesn't contain clinical notes. It just is the consumer's story, what they want to share of it. There's a page that carers can look at so they can - if the consumer wants them to, they can see where things are up to.

The consumer can journal in part of it. But the basis of it is one care plan, based on the consumer goals that all of the agencies work together, and I think it's something that health struggles with. Certainly with general practice, there's a lot of work gone into how do we share information with GPs so that we've all on the same page. But sharing it with NGOs who are outside of that fold is a next step and that's a bit of a challenge for

some people in health.

Q. Do you have any views on how health services for mental health and drug and alcohol are funded and managed currently?
A. Mmm. I guess what led to the alliance was there are multiple funding sources going to multiple providers, and how do you coordinate all of that, and that's - in Murrumbidgee with the alliance, we have all of the NGOs that are contracted, we have the LHD and we have the PHN, so we're all together.

There are other providers that are outside that, particularly private providers funded by Medicare, and we don't know who they are. So there's disparate funding sources to disparate groups, which is something that needs to be overcome if you're actually going to deliver the most effective services you can and maximise the impact of each individual service. Consumers don't just go to one service; they go to multiple.

Q. And do you see any sort of clinical impacts of the funding arrangements?
A. What I saw on the ground is where a provider is not connected with another provider, clients don't get the best outcome. So provider A doesn't know what provider B is doing, or may not even know that provider B is working with this consumer. So you're actually not maximising the impact that you could have for that consumer.

Q. What changes would you like --

THE COMMISSIONER: Q. Sorry, could you give me some examples of a consumer that's using multiple providers of the kind you're talking about?
A. Yeah. When we were doing the fact-finding for the service integration, we heard about a consumer who had six different care plans with six different agencies. Probably didn't need to see six different agencies, but they had been referred to them.

Q. And what were those agencies?
A. The LHD was one of them, and several NGO providers as well.

Q. In relation to, though?
A. Mental health issues.

Q. All of them were mental health, but from five other separate NGOs?
A. Yeah.

Q. Other than --
A. Yeah.

Q. Why was that occurring? Is it driven by the consumer, is it, partly?
A. No. It was driven by clinicians working with the consumer, who would say, "Why don't you go and see so-and-so, why don't you contact so-and-so." So they would have a pocket full of referrals and if they followed them up they'd have a pocket full of care --

Q. They are all counselling, psychological type --
A. Or non-clinical support. So it might be support for community living, if they needed that - a range of things, yeah.

DR WATERHOUSE: Q. Would that be a situation where dual diagnosis might play a role?
A. Yes, definitely.

Q. Because what sorts of services might they need if they had two diagnoses?
A. Look, it depends on what their primary problem is, because drug and alcohol use is usually driven by something else, and it might be a mental health issue, in which case mental health might be the priority issue to work with them on.

But there's also - they would need drug and alcohol for managing their drug or alcohol intake. If they have an intellectual disability, too, then there's intellectual disability providers now through NDIS, so the alliance has, at times, engaged with NDIS providers to better coordinate all of those services, better understand the system.

Q. And for the example that you gave, of somebody having six different plans --
A. Yeah.

Q. -- could that relate to GPs not being sure where to refer people?
A. At times, yes, yeah.

Q. Sorry, could you just repeat that?
A. At times, yes, yeah.

Q. What changes would you like to see to the way the mental health, drug and alcohol sector is funded and managed?
A. Yeah, I think different funding bodies have a different focus. So NSW Health has a primary focus on the severe end, the high-needs end. Commonwealth funding might be around primary mental health, and some people will at times need primary, at times need more intensive. So getting that better linked is something that we've been working on. I guess my --

THE COMMISSIONER: Q. So you're talking about the gap between primary care for a mental health issue and acute care for a mental health issue?
A. Yes, yes, and it continues to be a gap. The people who are most likely to say, "I can't get the service I need", are the ones who don't quite meet the NSW Health criteria for high-needs, acute; may not fit within the view of some of the private providers, et cetera, they're kind of in the middle. I think that is a continuing gap.

DR WATERHOUSE: Q. Do you find that some people need to access acute services because they were unable to access community services at an earlier stage?
A. Yes.

Q. Is that a frequent problem or just occasional?
A. I would fairly regularly hear of parents who were saying, "My son/daughter is not well and I can't get help for them", and they would get a view from one provider, "They're too unwell for us", and another provider, "They're not quite unwell enough for us", and they get worse and they end up needing the acute.

Q. And is that your experience while you've been the independent chair of the alliance or is that from when you were a clinician?
A. That's from when I was with the LHD, yeah.

Q. What positive benefits do you think that the alliance has brought?
A. I think all of the agencies being committed to working together. The relationships are really strong. The

meetings are kind of fun, because people have strong relationships now, which they didn't have in the past. So there's a bit of joking and levity around really serious subjects, but it's because they know each other well.

One of our standing agenda items is that a member service will do a presentation on all the services they provide. So on a rotating basis, the rest of the members get to hear that A provides all these services and this is how to contact them, and B provides all of these services. So it makes it much easier for the services to work together. They've got relationships and they've got information, and they're committed to working together.

DR WATERHOUSE: I have no further questions.

THE COMMISSIONER: Q. Can I just ask, in paragraph 11 of your outline, you say that one of the biggest barriers to the work of the alliance and the mental health and drug and alcohol sector is a lack of funding. More specifically, a lack of funding from whom and for what?
A. I guess that's the debate about who's responsible for what, and that gap in the middle, that NSW Health sees it is responsible for this, Commonwealth for that, and it's the in-between that's not well funded.

Q. Okay. I'm giving you a magic wand and you can create what you think is the kind of mental health, drug and alcohol sector health service that this region needs. What would it look like?
A. Yeah. Look, at one stage we were talking about kind of a bit of a protractor model, that you've got high needs, acute up this end, down to low needs and all the bits in between. I'd like to see a funding system that coordinates all of that and says, "We need this much for acute", blah, blah, blah, and then has some mechanism for pulling that all together, and it might be the alliance --

Q. That really needs the one entity coordinating it, doesn't it, not three or two?
A. Yeah, or just talking to each other.

Q. For what we have called the gap between the acute patients and those needing just a lower-level assistance with mental health or drug and alcohol, for that gap area, what would that involve to service these health needs of the population? Is it more community assistance, more

community centre assistance?
A. Yes.

Q. That's under-resourced?
A. Yes. LHDs are funded to provide acute.

Q. Yes.
A. And that's often translated as hospital care.

Q. Yes.
A. And there are probably enough beds in New South Wales, if they're well managed. And then there's community, which is kind of coming in and going out, and that sector is chronically short staffed, underfunded, so --

Q. Including in your area?
A. Yes. Yes. That leads to other issues where you've got clinicians carrying really high caseloads of quite unwell people, and that's pretty hard work. It's high risk. You are always second-guessing yourself and talking to your colleagues, have you got it right, what you are providing for that person.

Q. So the lack of funding creates (a) an access problem for the patient or consumer?
A. Yeah.

Q. Too big a burden on those providing the care?
A. Yeah.

Q. Pushes people into acute that could otherwise be managed well in a community setting?
A. Yeah.

Q. And means that the overall health outcomes for these areas we've been talking about aren't fully or adequately servicing the needs of the population?
A. Yeah.

Q. Is that fair?
A. Yes, and it also creates a retention and recruitment issue because it's pretty hard work. So --

Q. By that you mean it's hard to recruit people that aren't going to have the support to providing the health services that they're providing?
A. Yeah, and it's hard to retain them. They burn out.

Yep.

THE COMMISSIONER: Did anything come out of that?

DR WATERHOUSE: No.

THE COMMISSIONER: Mr Chiu might have some questions for you.

MR CHIU: Yes, Commissioner.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. My name is Hilbert Chiu and I represent NSW Health in this Inquiry. I just wanted to ask you some questions about that gap in the protractor that you were just describing?
A. Yes.

Q. Are you talking about the sub-acute part of the protractor where patients are not ill enough to be admitted to hospital, but are also needing help beyond what they could get in community, counselling and psychologists and psychiatrists?
A. I don't think - we do have some residential programs, and there probably aren't enough of them. But people are actually generally better off living in the community, maintaining their connections with family, friends, employment if they have it, et cetera. So it's not so much more sub-acute beds, although there's real value in those.

Q. Can I just pause there and ask you, what is available in the sub-acute sphere in the local health --
A. In Murrumbidgee?

Q. Yes.
A. There's a 20-bed sub-acute unit here in Wagga, yeah.

Q. Is that fully utilised?
A. Yes.

Q. What about outside of Wagga?

THE COMMISSIONER: Q. Is that at the hospital, the base hospital?
A. Yes, it's part of the mental health services at the hospital.

MR CHIU: Q. What about outside of Wagga?
A. No.

Q. No?
A. No. There aren't any mental health beds outside of Wagga.

Q. So if you have a patient who is in the community, say, 200 kilometres outside of Wagga --
A. Mmm.

Q. -- who is too unwell to be waiting for the next appointment from the local counsellor or psychiatrist, needs some urgent attention now, but is not unwell enough to be admitted into an acute unit, what happens to that patient?
A. They would be assessed by what we call the mental health emergency consultation service, which operates from Wagga, it's a 24/7, telehealth service, to the whole of the district. So they would be assessed by a clinician there, who would make a determination whether they actually need an acute bed or whether they could be managed in the community, and from there, the care follows.

But some of those don't actually need a hospital bed, and it may not be the best place for them, but having enough services in the community to follow them up intensely is a gap, I think.

Q. To your mind, the biggest gap is actually on perhaps the lower end of the protractor up to the middle, where people can be looked after in the community but just the resources are not there at the moment?
A. Yeah, it's kind of between the acute and the lower end, who may become more acute and need a bed, but if they're well supported in the community, they might go back down to the lower needs.

Q. And of course, it's not just you might be preventing them from becoming acute; you also might be preventing them from suicide as well?
A. Yes, and from all the losses that come with an acute episode as well.

MR CHIU: No further questions.

THE COMMISSIONER: Thank you. Did anything emerge from that?

DR WATERHOUSE: No.

THE COMMISSIONER: Thank you very much. We appreciate you coming, we are very grateful. You are excused. Thanks.

THE WITNESS: No worries.

<THE WITNESS WITHDREW

THE COMMISSIONER: I think the next witness can probably go not get sunburnt if they go into the normal witness box.

MR GLOVER: Yes. The next witness is Emma Field, Commissioner.

THE COMMISSIONER: Come forward, madam. Have a seat here. The other witness was over there because the sun was streaming in on that side earlier on.

<EMMA LOUISE FIELD, sworn: [10.46am]

THE COMMISSIONER: Thank you. Mr Glover will ask you some questions.

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Could you state your full name for the record, please?
A. Emma Field, Emma Louise Field.

Q. You're currently employed within the Murrumbidgee Local Health District?
A. Yes, I am.

Q. What's your role?
A. My substantive role is that I'm the director for integrated care and allied health services. I'm also currently the interim director in the short term for mental health, drug and alcohol in the Murrumbidgee Local Health District.

Q. If we just deal with your substantive role at the moment, can you just describe for the Commissioner what that involves on a day-to-day basis?

A. Yep, sure. So my role has - I have the strategic oversight and support for a number of programs, predominantly community programs, in the Murrumbidgee. I provide guidance, leadership across a number of those portfolios or those portfolios, so community programs, like community nursing, your oral health, your public health, population health programs, BreastScreen, aged care services, so predominantly community.

Q. When you say "community", are these programs delivered in the community setting?
A. Yes, they are.

Q. And the interim role you have, can you describe that for us?
A. Yeah. So interim director for mental health, drug and alcohol. So again, that's strategic and support and guidance and leadership over how we deliver mental health and drug and alcohol services. I've just been in that role for two months.

Q. And I take it that there's a recruitment process under way; is that right?
A. There is, yes.

Q. How long have you been in your substantive role?
A. Two and a half years, January 2022.

THE COMMISSIONER: Q. Were you here while the previous witness was giving evidence?
A. Partial.

THE COMMISSIONER: I just wonder, are you going to follow up with any observations with this witness about the previous witness's evidence on mental health issues? If you are, I will leave it with you.

MR GLOVER: I hadn't planned to, but I can.

THE COMMISSIONER: We'll wait until the end and I'll do it if you - yes.

MR GLOVER: We might get there anyway. We will see how we go.

Q. In terms of the community programs that you have responsibility for delivering, are they limited to those

delivered within this district or do they also relate to some other districts?
A. They do. So predominantly within this district, however, there are three that sit across Southern New South Wales as well, so that is your public and population health programs and BreastScreen services and oral health services.

Q. In delivering the community programs that you've described earlier, do you interact with the primary health network that's in the region?
A. Yes. Yes, we do. So a large part of my work as a director is obviously around that stakeholder engagement in that community space and we do work with the primary health network on a number of areas.

Q. How do you go about engaging with them on those programs?
A. Yeah, so we have a joint collaborative agreement, but we also have programs that we work jointly on. One of them, namely, is around the collaborative commissioning piece, and that's in my evidence there to talk about that, and we have a number of ways we work with them.

One is around we have a joint board, a joint board meeting as well; we have that collaborative agreement which we signed this year; and also we have a joint patient-centred co-commissioning group, that we work on the delivery of a number of programs, collaborative commissioning being one of them. So we work with them on that as well.

Q. We'll just break that up a little bit.
A. Yes.

Q. You mentioned collaborative commissioning.
A. Yeah.

Q. Can you just describe that for us, please?
A. So collaborative commissioning is a statewide value-based health initiative.

Q. Just pausing there, statewide, that's being devised by the ministry; is that right?
A. Yeah, it's not rolled out across all LHDs, there's only a number of LHDs that have collaborative commissioning in place at this point in time. We are one of those. We

commenced our - we commenced our planning in collaborative commissioning in 2019, and kicked off in 2022.

Q. And what does the initiative seek to achieve?
A. It seeks to have localised solutions to health issues for that local community and identify gaps where there aren't care pathways for people to access those particular care - the care in that community. So it's a localised solution to joining up resourcing as well, having both the PHNs, so in the - the primary care providers, and the state-based providers, to work together to deliver on those care pathways.

Q. And that's the collaborative element of collaborative commissioning; is that right?
A. It is, yes.

Q. Is there a particular focus of the collaborative commissioning initiative within the district?
A. There is. So in 2019 we worked on identifying what are those - what are the very - the issues for our communities, and we chose COPD, which is chronic obstructive pulmonary disorder and heart failure, congestive heart failure.

Q. When you say you chose those to, what was that process?
A. That was a process of where we looked at a lot of population health data, access issues in our communities, and we could see that there were some fairly significant concerns around when people do come into our hospitals with either COPD or CHF, they're over two times more likely to be admitted for what we would call low acuity.

We also know that they didn't have access to free public services for those particular areas, so very limited access, and specialist access. So there was lots of population health undertaken around - data looked at, but also access looked at as well to see, you know, does that all marry up? So for us it's COPD and CHF for that reason.

Q. And they are the two initial focuses of this initiative; is that right?
A. Yes, they are, yes.

Q. Is there an intention to roll it out in other areas?
A. In what regard, sorry?

Q. Well, the COPD and the CHF are the current focuses of the collaborative commissioning initiative --
A. Yes.

Q. -- is there an intention to work on other health issues within the population under the umbrella of collaborative commissioning into the future?
A. Yes. So with the - we've - certainly with the PCCG which I mentioned before, which is that patient-centred collaborative approach, so we jointly work with the PHN in how we govern how we roll that out and monitor that.

We now have included two other areas for us to work jointly on, so that has started, one of them being the statewide diabetes initiative and how we regionally plan for that, and the other one is our Head to Health services, so our mental health services, that's being rolled out in Wagga and Young. So we've brought that into that governance mechanism between the PHN and the LHD to ensure that we've got that good collaborative approach to how we work.

Q. We might just explore the PCCG a little.
A. Yeah.

Q. That's the patient-centred co-commissioning groups?
A. Yes.

Q. That's part of the collaborative commissioning rollout; is that right?
A. Yeah, it is

Q. Who sits on that group?
A. So both CEs, so the CE of the Murrumbidgee Local Health District, the CE of the Murrumbidgee Primary Health Network, a number of the executive positions in the Murrumbidgee Primary Health Network, and myself and a number of other executive positions in the LHD.

The way it currently works is we have, as I said, those three areas that we've - because we've rolled out extended to those two, so we'll manage those, and people coming in to the PCCG to provide that update and decision-making points for us to discuss.

Q. So what's the remit of the group? What is it

responsible for and how does it deliver on those responsibilities?
A. Yep, so it looks at obviously the - you know, the funding elements and what funding is being expended in that month. Also, what decisions need to be made jointly around upcoming - it might be that we need to look at upcoming funding, that we're going to be focusing the direction in, or it might be that we need to look at building an advisory group that we need to, you know, get permission off to bring certain parties in. So it's true joint planning - joint decision-making, and that's essentially its role.

Q. You mentioned funding?
A. Yeah.

Q. How are these initiatives being funded - that is, under the umbrella of the collaborative commissioning --
A. Mmm-hmm.

Q. -- how are they being funded at the moment?
A. Yeah, so initially we received a parcel of seed funding for collaborative commissioning.

Q. From?
A. From the ministry, NSW Health, and that is to set up those care pathways into our local community, knowing that a number of those pathways don't exist and we need to build that in the first instance.

The goal being that they become self-sustaining. So after three years, there will be a self-sustaining nature. So that's the goal of collaborative commissioning - everything that we're building, we would look at how do we embed that into our BAU moving forward.

Q. When you say "self-sustaining", what do you mean by that?
A. I mean aligning to current funding mechanisms and pivoting in to some of our BAU. So, for example, what I mean by the pivoting into a normal - into a BAU, it might be that we're utilising some of our community nurses, which we have, we've realigned some of our funding that we already receive for our programs to work on chronic disease with COPD and CHF. So that's where we've realigned that into that to be part of their BAU, and then a number of other care pathways we need to align to existing funding streams.

Q. So when you speak about funding in that context, that's state funding?
A. Yes, but it can also be Commonwealth. So we're working with the PHN. They - one of the areas that we've described in here is around the winter strategy. So they particularly incentivise GP clinics in our district to focus on that COPD and CHF cohort in winter. So moving forward, that's obviously Commonwealth funding so they will look to see how they can realign that funding into the normal mechanisms for Commonwealth funding.

Q. We might come back to the winter strategy in a moment.
A. Yeah.

Q. But what you've described there is looking to embed care pathways that straddle both primary and acute care settings; is that right?
A. Yes, correct.

THE COMMISSIONER: Q. Can I just ask, what does setting up a care pathway for congestive heart failure or COPD involve?
A. So - well, setting up a care pathway, in terms of the collaborative commissioning.

Q. Yes.
A. Initially, obviously we have - we know that there were gaps, that's why we've gone down this pathway. We know that when you --

Q. So there's people with these chronic conditions in your health district - it's more than the state average, is it, or it's a real --
A. It is.

Q. -- chronic condition problem for your health district?
A. Absolutely.

Q. So these two were chosen as chronic conditions --
A. Yes.

Q. -- that some better outcomes could be obtained if things were done differently such as setting up these care pathways, and then what does that involve?
A. Yeah, so traditionally, patients who come in - from an acute setting, we would see those very acutely. So for

us --

Q. They're going to the hospital?
A. Absolutely. So these are people coming into your hospitals, and traditionally and historically, that's where they were cared for. This is about looking at how do we prevent people coming in to the hospital in the first place. That's one of the goals of collaborative commissioning. So how do we keep people in the community, where appropriate, and safely to do so?

Q. So part of the care pathway is early intervention?
A. Mmm-hmm.

Q. And part of the care pathway --
A. Managing.

Q. -- providing it's safe to do so, is to manage the people with these conditions so that they're not presenting to the ED?
A. Correct, yes.

Q. Or occupying a hospital bed?
A. Yes, yes. And there's quite extensive - so quite extensive work done in that joint development phase from 2019 to actually walk through a care pathway for each of these cohorts. So we could see where people were going and we could see that in the acute setting. We also know what is best practice, that happens, should be happening in the community, around screening and we talk about that a little bit, around screening in pharmacies, and also good management and care planning in primary care.

Q. And these care pathways I assume were all developed through, in part, the clinical advisory group?
A. Yes.

Q. And input, perhaps, from others as well --
A. Yes.

Q. -- in the joint governance committee --
A. Yes.

Q. -- I'm not sure. And you said there was seed money --
A. Yes.

Q. -- from the ministry?

A. Yes.

Q. Do you remember how much that was?
A. Over the three years, just over 11 million, from memory.

Q. Eleven?
A. Eleven million, from memory, yeah.

Q. And then, there was a realignment of existing funding?
A. Correct.

Q. Does that mean, leaving aside that 11 million as the seed funding to get things up and running, then it's money from the same budget but it's being taken from areas where perhaps it's not needed as much and put into the care pathways for these two conditions; is that --
A. Yes. And it's really important that we did that to look at where could we actually realign some of that. When I say, "realign", I mean using existing services where they naturally are seeing these cohorts anyway.

So they are naturally seeing these patients coming in to their services. It's about then how do we upskill those people to be working on those care pathways and creating the best possible outcomes for those patients, and when we talk about that, we talk about not coming into our acute setting. So really, it's about realigning professionals, their skill base, to upskill them in that space, yeah.

MR GLOVER: Q. The Commissioner mentioned the clinical advisory group --
A. Mmm.

Q. -- in that passage, and I think in answer to his question, you said that they were involved in designing the clinical pathway; is that right?
A. Yes.

Q. Who sits on the clinical advisory group?
A. Yes, it's quite a dynamic group. It's - we've got GPs; we have nurse practitioners; we have CNCs; we have a number of people from the collaborative commissioning project team that sit there; consumer rep, so there's - it's quite diverse.

Q. A wide range of representatives from different fields;

correct?
A. Yes.

Q. And you've mentioned in some of your answers a short time ago the design process of these care pathways?
A. Mmm.

Q. How are they actually implemented?
A. So with the implementation component of it, I mean, it's something that is - depending on what we - and this collaborative commissioning is very unique for each district. For our district obviously we've chosen care pathways that we don't have and that are gaps --

Q. Just pausing there, by that, do you mean other districts may focus on a different issue?
A. Absolutely, yes, yeah.

Q. So the care pathway that you have designed is to address the local needs as, you've mentioned earlier, were discovered during the research phase; correct?
A. It is, and what those gaps are and what we have in our providers in our district. So the implementation phase is very considered. We do a wide range of obviously consultation early on. We know who our partners are and where the touch-points are, and we have a commissioning, as I said, collaborative commissioning team, project team, which consists of various aspects, so our - we have an IT, we have, for example, an IT member who will work closely in the implementation of how we want to implement something like the consumer app that we've spoken about, and that team wraps around that care pathway to implement across the path.

Q. Just going back a little, you mentioned in that answer, you know who your partners are?
A. Yeah.

Q. Do you mean those involved in delivering on this care pathway?
A. Yes.

Q. Who do you have in mind?
A. Who our partners are?

Q. Yes.
A. So we'll have - we may have our specialists in - so,

respiratory physicians, our cardiologists, we have our ED teams, we have our GPs in our community, we have physios, we have pharmacies, pharmacists, they're just to name a few. Practice nurses --

Q. So these - I'm sorry, I cut you off.
A. Yeah, Practice nurses, a very important role there, too, yep.

Q. So the care pathway may touch upon a wide range of clinicians --
A. Yes.

Q. -- and others involved in the delivery of healthcare services across the region; correct?
A. Yeah.

Q. During the implementation phase, how have you and your team ensured that there is, if I might call, buy-in from each of those elements of the healthcare sector?
A. So we really are - having that collaborative - the PCCG, so that really close working relationship with our primary health network, they are there very much for the primary care aspect of our engagement. They provide us with that support.

We also have very - we also have a collaborative approach with any of our GPs, and in the winter strategy is a good example where we have 34 practices that we engage with regularly around the management of those cohorts. So we - I would say the collaborative commissioning piece is probably the strongest engagement in programs that - yeah, in our district, with GPs. So that's part of our everyday work that we do for this particular program.

Q. And in delivering the care pathway, there are a number of strategies involved, is that right, or initiatives?
A. A number of initiatives, yes.

Q. One of them being the winter strategy that you have referred to?
A. Yes.

Q. Are there others?
A. There are. So one of the others that we've implemented is the outreach heart failure model. So that is delivering outreach - delivering the capacity to do

diagnostics in cardiology, in primary care. So we've now been able to deliver that in four areas out in the western districts, so Lake Cargelligo, Temora, Griffith and particularly working with our Aboriginal medical service in Griffith as well, where we have --

Q. When you say "diagnostics" in primary care --
A. Yes.

Q. -- just explain that.
A. Yes, so using an echo machine in primary care, so in a GP clinic with a sonographer and a cardiologist. So they --

Q. Is that a service being delivered by the district in that setting or by the primary care provider in that setting?
A. Both. So it's true collaboration because we actually have the primary care providers, being the GPs; we have the cardiologist, who we have engaged in that process, and the sonographer. We also have our nurse practitioners going in, and there's a very large amount of work up to that day with our heart failure team. So it's a true collaboration. So it's not just one area delivering.

Q. So in that example, where you have people from primary, acute, perhaps allied health, all working together, how is that funded at the moment?
A. Yeah, so it's a combination of funding. So we have some realignment from some of the seed funding to provide the cardiologist, so the cardiologist receives, obviously, a fee for their services for the day. We also then have our services that have been realigned - they're the realignment of the cardiac heart failure nurses.

Q. Just pausing there, the first is redeploying some of that $11 million in seed funding?
A. Yes.

Q. The second is what you have explained to the Commissioner earlier, about some redirection of existing funding within the district budget; correct?
A. Yes, it is, yes.

Q. Is there another?
A. And there is obviously the primary care. They are obviously going - using their MBS billing through that

process as well.

THE COMMISSIONER: Q. And to that extent, there's some Commonwealth funding through that process?
A. Yeah. Yeah, there is. That's through normal MBS, Medicare, yeah.

MR GLOVER: Q. And pulling those strands together, do you have a view as to how well that, as a funding mechanism, works to deliver that particular initiative?
A. Look, it's challenging because this work is what we focus a lot on in the next 12 months. So the next 12 months, prior to when this finishes in October 2025, we will look to be aligning where all these streams - where is all the funding that we need to align to and what is outstanding. It's definitely challenging, but that's what we're seeking to do.

Q. Is the challenge you are referring to aligning funding projecting forward?
A. Yes.

Q. Other than the --

THE COMMISSIONER: Q. Sorry, is the challenge finding the money?
A. The challenge is - I think with collaborative commissioning the challenge is finding the money because - and it is also aligning it to existing funding, and there is some merit in doing that, I don't want to say there isn't, because I think we do need to pivot. That's - we do need to move with the times.

What I will say is that innovation - and this is true innovation, so collaborative commissioning is absolutely what you would see as that true collaboration between Commonwealth and state funded programs working together to deliver a local pathway. Innovation takes longer than three years. That's the challenge. So we won't see some of the benefits and the kick-backs for it for a lot longer.

Q. But one step in this, regardless of how much money there is, this is, at least in part, designed - obviously it's to get best health outcomes, but it's to ensure that, of what money there is, it's targeted to the best outcomes that do the most good for the population?
A. Absolutely. And particularly with the outreach

clinics, you will see that in that evidence as well. You will see that some of the outcomes that we've had, they would never normally be picked up in a primary care setting. So this is really very innovative, to be doing this work, and delivering care to people that would normally have to come to a major centre, but also then pay for these services as well. So innovative and, yes, something that, you know, we're seeing short term - as you can see, some short-term results, but we'll take a bit longer to see that long term.

Q. The example you have given of this outreach heart failure diagnostic clinic, is that being evaluated?
A. Yes, it is.

Q. Who is doing --
A. The George Institute. So we're just starting that this year. So we'll have more of that, the valuation outcomes, you know, in the later half.

Q. That will involve no doubt - well, you tell me, but evaluation of, one, improved health outcomes, but also things like less time in EDs?
A. Correct. So it will --

Q. Hospital, all of that?
A. All of that. So it will be looking at how often are they presenting - these two cohorts, how often do they present to EDs, how often are they admitted? Because we know these two cohorts are admitted - twice as likely to be admitted. So have we made a dent in that? Has that lowered? So all of those metrics, but also, how do the patients feel about the care as well? So that experience of care, yeah.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. How long has that program been up and running, the outreach diagnostic program?
A. Oh, gosh, last year - October 2022, yeah, was when we kicked off.

Q. You mentioned, in answer to the Commissioner, some evaluation that would be done by the George Institute. We might explore that a little further a little bit later, but have there been some measurable outcomes from the outreach heart failure diagnostic clinic initiative that have been

realised to date?
A. Yes. And we can see that - just from those nine clinics that we've run in western - and when we talk about "western", we're talking west of Wagga, so we go out Lake Cargelligo, out that way, so it's quite isolated. So those nine clinics that we've seen 97 patients, we've had 21 new diagnoses of heart failure in those particular clinics; we've had 28 referrals to regional and tertiary hospitals; and we've had 22 people linked with community services, and these would be people that would normally present to an ED. So this is real diversion into, and changing lives, yeah.

Q. Another of the initiatives under the collaborative commissioning umbrella that you've referred to is the winter strategy?
A. Mmm-hmm.

Q. You mentioned that a couple of times this morning. Can you just describe the winter strategy for us, please?
A. Yeah. So this is about incentivising general practice throughout that winter period to wrap around care for COPD and CHF. We know particularly COPD will exacerbate in winter, so it's really important that these people have enhancement in their care in the GP clinics over that period.

Q. And how are the general practice clinics incentivised to provide that wrap-around care in that period?
A. Yep, so they receive visits from the primary health team, so the engagement team, and that's run out of the primary health network. So they are increased, those visits. Education is given around working with patients with COPD. There will be increased certification around spirometry in how to measure people's lung capacity in GPs, in GP practices. We then measure how many patients have been - how many patients have been in those clinics who have received that enhanced care. So we can see in this latest winter period from last year, we had an extra 901 patients who received that enhancement.

Q. And that engagement team I think you said was within the remit of the PHN, did I hear you correctly?
A. It is. It is, yes, yes. Again, we're all working together but the alignment of the resources predominantly sits with the PHN in that space. So they're going into these spaces, upskilling practice nurses, upskilling GPs, providing support around how to utilise their IT equipment,

to flag if there is someone who comes in with particular medications and presentations. So it's quite eclectic in that regard but the PHN are absolutely the people going in and doing that work.

Q. And are you able to measure the engagement with that program by practices within the region?
A. Yes. So we have - we've seen - and this is something that we measure each year. Last year, we've signed - where they signed 34 practices out of 89. We've got 89 practices in Murrumbidgee, 34 of those now were signed with that winter strategy, so that's a fairly big increase.

Q. And you mentioned about 900 patients receiving that enhanced care?
A. Yes, in the last winter period.

Q. Have you been able to measure any outcomes based on the increased care to that patient cohort?
A. Well, that's what the George Institute is doing this year, so --

THE COMMISSIONER: Q. Were they chosen for a particular reason, the 901?
A. So if they're coming in to those practices, so those 34 practices, they are flagged on the system with that COPD flag, so that's part of the incentivisation. Yes.

MR GLOVER: Q. These are patients who may visit one of the --
A. GPs.

Q. -- 35 practices who are part of the program; is that right?
A. Correct, yes.

Q. Who have COPD?
A. Yes.

Q. And then are - "tracked" is the wrong word, but feed in to the --
A. Provided, yes.

THE COMMISSIONER: Q. So all 901 of these patients have the pulmonary disease, do they?
A. Yes. And so they may be given - a good example of what they would receive is like a sick-day action plan. So

they may look at how to manage exacerbations, with the ultimate goal that they're not going to present to an ED. That normally would have been the pathway, how do they manage exacerbations. So that's the predominant goal of winter strategy.

Q. I suppose I could Google this, but this pulmonary disease is a lung problem?
A. Yes.

Q. Breathing?
A. Yes.

Q. And how do you manage it? How do patients manage it?
A. So, I mean, there's all different elements of it, but essentially, it is managed with, you know - there's medication management, there is exercise management, pulmonary rehab, there is all of those opportunities there within the winter period for us to ramp up, for want of a better word, to support them through that process, yeah.

THE COMMISSIONER: Okay, thank you.

MR GLOVER: Q. And just to make sure I've understood your answer correctly, the success of the program in preventing the presentations to ED in this patient cohort is something that the George Institute is looking at?
A. Absolutely. That's one of the - one of the parameters that we will be measuring as an outcome.

Q. Are there others that are being measured?
A. Admissions. So if they do present to ED, what is the likely - how many people are admitted from that point, what triage category they - we'll be looking at what triage category they present with. We see that it is usually a 4 or a 5, which is less than 2- or 1-hour triage category in EDs. So we'll be looking to see how they present into those as well.

Q. And is the relevance --

THE COMMISSIONER: Q. Is the funding for the George Institute evaluation part of the seed money?
A. Yes, it is. It is, yeah.

MR GLOVER: Q. And is the relevance of the admissions measure to determine the level of acuity of those patients

who do actually present to ED in that period; is that right?
A. Yes, correct.

Q. And when is the outcome of the George Institute's work?
A. They're starting soon, this year, they're currently just in the process now. So we would hope to have some - obviously we're coming out in October 2025, is the end date, so we would then obviously have that completed by then.

Q. Sorry, the October 2025 end date, what's that?
A. That's the seed funding.

Q. I see.
A. Yeah. That's our complete collaborative commissioning implementation and seed funding. That will finish then.

Q. Is there any certainty to the program beyond October 2025?
A. Look, I think that's where we're going in the next 12 to 18 months, is where we'll be focusing around, one, having a look at where we can align the funding to existing sources; but certainly I have no further information on --

Q. So after October 2025, that's when it's, at least conceptually, thought to form part of BAU if it's going to continue; is that right?
A. Yep, that's right.

Q. Are there any other initiatives under the collaborative commissioning umbrella that are being rolled out?
A. Look, one there I think is really important to note is the pharmacy screening. So we've engaged pharmacists across the district to play a really important role in patients' journey for COPD and CHF, so this --

Q. How are they doing that?
A. With a screening tool. So a screening - they've received training around some - a number of questions to ask people, patients, that are presenting into pharmacies, which would look for exacerbations, and then transfer of care into the relevant area that they - based on the screening tool. So do they need to go back to their GP, and that would be recommended. So there's been a number of

pharmacies that have taken that up as well.

Q. Just break that up a little. How are the pharmacists or pharmacies involved in the process identified?
A. So they're through an EOI process. So an EOI goes out to all pharmacies to say, "Would you like to be part of this strategy?" And they apply through an EOI process and then they are - they receive the relevant training, and they receive incentivisation money as well.

Q. What has the take-up been like?
A. It's been fairly good. I mean, we had 11 pharmacies in the first year, so - and we'll see an increase again for this year. We've already received a number of fairly significant interest. So the 11 pharmacies certainly is a good number.

THE COMMISSIONER: Q. What does "incentivisation" mean?
A. They receive from that seed funding a certain amount of that, just block funding at this point. We will look at this differently for this year to see whether we are - and that's what we're just doing at the moment, looking at how we pay that. But essentially it's a block amount of money for incentivisation to say, "Here is what we want you to do. We want you to be able to screen these patients and do that transfer of care, if appropriate, to a GP."

So rather than someone coming in and getting that very transactional, filling a script, it's about them having a bit more of a discussion with the pharmacist and, if appropriate, clinically appropriate, they either go to an ED or their nurse or their GP or - so it's allowing that transfer of care.

Q. And the block funding, how was that - was it based on population in the area or --
A. Yeah, yep.

MR GLOVER: Q. When did the program commence?
A. Last year. So in the first winter period.

Q. So the screening tool is delivered to the pharmacists who are involved in the program and they are given training; correct?
A. Yes, they are.

Q. And are they given training on how to identify the

patients who may be suitable for screening?
A. Yes, they are. So that screening tool has a number of elements in that that would then guide them in terms of, well, one, first of all, who is, you know, an appropriate patient in the COPD cohort; but also then the screening tool has a number of questions around where they - what the next step would be.

Q. Has there been any work done to monitor the effectiveness of the program to date?
A. Again in the George Institute evaluation and monitoring tool.

Q. Leaving aside the work being done by the George Institute, have you or your team been able to monitor the progress of that initiative over the last 12 months?
A. Yeah, we have. Throughout the process we're always engaging with our partners, that's part of this collaborative commissioning, that's part of the work. Anecdotally I know that this has been reported back in our PCCG that pharmacists do actually find this really quite rewarding work.

This is a bit - obviously they're engaging with their - engaging with patients and being able to have that realtime effect in transferring care to the right place, right time approach. They have reported back that it has been very professionally rewarding, rather than that transactional approach.

THE COMMISSIONER: Q. Forgive my naivety, if that's the right word, but the screening program --
A. The tool, yep.

Q. -- a customer comes into the pharmacy --
A. Yeah.

Q. -- are they screened on the basis of the medication they are getting or, you know, you're buying shampoo and the chemist says --
A. It could be that they --

Q -- "Look, you look like you're out of breath. Can I ask you some questions"? How does it work?
A. Yeah, so it could be - so, for example, if they're registered with the pharmacy, pharmacist, that's one way, but it could be that their titration - for example, that

they're requesting more medication, that's a flag. So that's part of the tool, is then to go out and have that conversation with the patient. Because if they are coming in seeking more treatment, then that would be an exacerbation, yeah, and normally, that would be a very transactive approach.

Q. The pharmacist is trained to look for clues --
A. Correct, yes.

Q. -- about this particular chronic disease?
A. Yes, yeah.

MR GLOVER: Q. Is it fair to describe this program as a pilot stage at this point in time?
A. Yeah, I mean, it is certainly within this three-year period, yep.

Q. And aside from the professional engagement of the pharmacists who are involved, has there been any data or results on the success of the program in identifying the appropriate patients and then diverting them to a care pathway?
A. Yeah, so early data that we have received, we can see their care pathway. I couldn't give you an exact figure, I could take it on notice, but certainly we are monitoring that care pathway for - so people who are diverted from a pharmacy. So that is currently being --

Q. Appreciating it's early days, but is that data giving you an indication of the success or otherwise of the program?
A. It is, as I said, early data. But again I want to go back to the George Institute evaluation and monitoring, which is a very robust tool. So that's where we will get our rich information from. But early data is indicating that, yes, the implementation of a screening tool in pharmacy is purposeful for that linkage back to GP primary care, and therefore, ED avoidance, but again, I'd like to just hold fire on the, you know, robust findings. Yep.

Q. That's understood. In an earlier answer you mentioned an app?
A. Yes.

Q. What's the app that you were referring to?
A. So the CareMonitor app. So this - the CareMonitor app

is a digital approach to how patients can manage their illness, so COPD and CHF.

Q. Is that an app that has been developed by the district under the collaborative commissioning umbrella?
A. It is, yes, with the PHN. So the collaborative commissioning, PHN, MLHD, have engaged a developer, an app developer, which they - is CareMonitor, and essentially what it is, it's a patient-driven, owned app where patients put in their measurements around BP, it could be weight, how they feel in terms of breathlessness, tiredness - all these different elements.

That can be then - that can be read by their GP, which is - or their community care nurse, whoever is engaged in their care pathway. So permission is given from the patient to their care providers to access that app.

Q. Can the ED see that data if that patient presents?
A. I would say at this stage probably not the ED. It would be more their care pathway. It can be - because the ED - because their community care nurse has engaged in that and given access to it in the app, but I don't think our ED clinicians would have access to that app.

Q. When you speak of the care pathway in that context - that is, those with access to the data from the app - are they the care providers within the community setting rather than the acute setting?
A. Exactly, yes.

Q. I take it the app is up and running and being used?
A. It is.

Q. What has the take-up been in its utilisation?
A. Yeah, and predominantly we've seen this in GPs, so GPs have taken up this initiative, and from the last count, we had just over - I think we had 25 GP practices that were registered to use CareMonitor.

Q. And what about the patient utilisation?
A. I think around 40 patients, yep. So it's early, very early in its stages, yep.

MR GLOVER: I note the time.

THE COMMISSIONER: Q. Not every patient an app is

suitable for, I suppose?
A. Absolutely, yes.

Q. It's for people who have - you've got to have the phone?
A. Yes, you've got to have the phone and also, too, it's - and the patient - it's patient driven. So it must be that the patient is feeling that that is valuable.

Q. Those who know how to adopt that sort of technology?
A. Yeah, and it is valuable.

MR GLOVER: Is that a convenient time?

THE COMMISSIONER: Yes, it is. We will take a break until 11.50. Thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: Is Ms Field here?

Yes, Mr Glover?

MR GLOVER: Thank you, Commissioner.

Q. Just before we turn to some of the what might be described as challenges in the further implementation of the collaborative commissioning model, yesterday we heard some evidence about a range of initiatives across the district under - variously described as urgent care clinics or rapid access clinics, and a model whereby general practices are holding appointment slots open for people to be referred into. Are you familiar with those initiatives within the district?
A. I'm certainly familiar with the urgent care services that have been funded through the ministry. And the one that Dr Shenouda referred to yesterday, I'm not - I don't have intimate knowledge of the primary health network planning but I do know that it is currently in planning for how they'll manage an urgent care service across.

Q. Can we perhaps start with the urgent care services delivered through the district that you've mentioned?
A. Yes, so --

Q. What are they?
A. So that hasn't started just yet either. So we've

received funding through the ministry to provide an urgent care service, which will be provided as an extension of the rapid assessment clinic, and it will be delivered through that pathway. Healthdirect will be the referrer into that urgent care service. We're still in those planning stages as well.

THE COMMISSIONER: Q. What's the difference between urgent care clinic and rapid access clinic?
A. So rapid - the urgent care service will be seeing patients who have been referred in through the Healthdirect pathway. So it'll be people who ring Healthdirect. So our rapid assessment clinic is our own - yeah - service.

MR GLOVER: Q. When you say it's an extension of the rapid access clinic service, what did you mean?
A. I mean, I suppose, the actual physical - it will be located in the same area, and it will have elements that - where there is a natural extension past the rapid assessment clinic normal profiles that they would see. Yep.

Q. And I take it that you heard some of the evidence given by Professor Shenouda yesterday?
A. I did, yes.

Q. And you heard him describe the program that's under implementation whereby practices will hold a couple of appointment slots open?
A. Mmm-hmm.

Q. Do I understand that that's something that sits within the remit of the primary health network?
A. Correct.

Q. Are you aware of how that program will be funded?
A. I know that it was funded through the NSW Ministry of Health in their urgent care service funding that they released. However, it's sitting with the primary health network through their submission.

Q. So is that funding released to the primary health network --
A. Yes.

Q. -- to deliver that program that Professor Shenouda spoke of yesterday?

A. Yes, that's my understanding.

Q. Thank you. You mentioned in your evidence earlier today some of the challenges around funding models for the implementation and then transformation to BAU of the collaborative commissioning initiatives. Are there any other barriers other than the funding difficulties that you spoke of earlier?
A. I think one that we should acknowledge is the workforce challenges for this model, and that's certainly something that all of New South Wales, but particularly rural/regional is having significant challenges with, and when we are doing new pathways and we're needing to employ skilled health professionals in these areas, there are - there have been some challenges to employing those particular health professionals.

Q. When you speak of employing health professionals, are you referring to employing people within the district to implement and support those programs?
A. Within the district, but not so much by the - so within the LHD, it could be, for example, a cardiologist; it could be our primary care services, like, for example, GPs. We know that we are seeing less and less GPs in the district. Therefore, that has a flow-on effect to the delivery of this program as well.

Q. And does that extend to access to primary care and allied health professionals of various kinds in the more remote areas of the district?
A. Yes, it does. It does.

Q. What, in your view, can be done to ensure the success of these initiatives in those areas, acknowledging those workforce challenges?
A. So I think we have to be - remain flexible in how we fund these programs. So that's something - we have to be flexible in that when we set out to commence these care pathways, with the notion of, yes, we'll hire a cardiologist or, yes, we'll need a physio to do the cardiac pulmonary rehab, whatever it may be, we need to be flexible enough in these care pathways to divert where we might need to go out to tender, for example, for that particular skill set. We might need to go out to have an existing provider in the district to put up their hand to be able to provide that, as opposed to on-boarding a staff member to do that. So I think we need to be flexible in

our approaches. So that should be part of how we're funded.

That also then takes time. It can reset a little bit of our time and how we progress it. So I think that, in itself, is probably one of the biggest challenges we have, is that it's not a one size fits all for every care pathway and every community either. So that flexibility needs to be noted, built in and expected.

Q. Does that flexibility extend, perhaps, to the district providing might what otherwise be described as primary care services into those more remote areas?
A. Only where there's service failure. So we have - to be really clear, we don't want to go into primary care where there is existing primary care services. That is not part of our remit. We only go where there is service failure or we don't have a provider.

A good one is around what you just said about allied health. It might be that we don't have a physio in Tumut to do the pulmonary rehab, however, we know we need that because that's a really important part of the care pathway for COPD or for whatever it may be. So we need to be able to go out and - to the market and ask, "Do we have a provider in that district?" So we need to be flexible enough that we're actually really truly aligning ourselves to the intent of collaborative commissioning, which is local-built solutions for local communities.

Q. When you use "service failure" in that context, what do you mean?
A. I mean we don't have a primary care provider.

Q. What about if there are services but they are not sufficient to enable those who need them equity of access to them?
A. Yep.

Q. Would that be an occasion where there'd be an opportunity for the state - that is, NSW Health - to step in and supplement those existing services?
A. Yes, and I think that's a great example of the cardiac outreach model. So that's something where people did not have access to - equitable access, I'll say, to cardiology services in those really outpost western areas, they normally wouldn't have access to that. And also, they

would - don't have free access. So that's a really good example.

Q. So does that mean there's a distinction perhaps between there being an existing service and the adequacy of that service to meet the needs of the local population?
A. Yes.

Q. And if there is, albeit an existing service but perhaps not an adequate one to fully meet the needs of the population, is that an area where there's scope far the state to step in and supplement the service?
A. There is. I think that needs to be really carefully undertaken, though, because if there is a service - and I would say in this case, we haven't probably gone down that pathway because we're looking at where there isn't a service, more so.

Q. Yes.
A. And where there isn't a free service. Where there is - and that's about that equitable access. So, to be clear, in this collaborative commissioning, it's about where there isn't access, first and foremost. If it's - certainly equity is the next part of that.

Q. Is another of the programs that is within your responsibility the emergency department to community program?
A. Yes.

Q. Can you just describe that, please?
A. Yes. So that's a statewide initiative, integrated care initiative. There's a number of those initiatives under the integrated care banner, ED to community is one of those, and it's about how we wrap around patients who present to an ED 10 or more times in 12 months, they then are flagged on what we call a "patient flow portal", and they are - we pick them up and we case coordinate their care, so that we understand what their needs are better, and we look at what their care could be in the community to boost that up and what are some of their needs, with the ultimate goal of their ED presentations reducing, their access - their ED access reducing, but also their experience of their care is obviously better for them.

Q. So you said this is a statewide program?
A. It is.

Q. It's in other districts other than yours?
A. It is. It is, yes.

Q. And the criteria of 10 or more presentations --
A. Mmm-hmm.

Q. -- are you aware of how that was arrived at as being a trigger point for this program?
A. I don't have the history on how that was arrived at.

Q. So let's just break it up a little. You have a patient who has presented 10 times in the 12 months. What is the process that is followed to provide what you have described as a "wrap-around" care of that patient?
A. So what we use - we use a platform called the patient flow portal. So --

Q. That's a part of the district's system?
A. It is. It's part of the district's, and it's statewide. It's used for a number of other functions, but in this particular area, this is for EDC, they will be put into what they call an ED to community part on that patient flow portal. Patients will appear if they meet that criteria - they're under the age of 70. I should have said that to. So if they meet that criteria, they will appear on the patient flow portal.

We have a team of integrated care staff that monitor that, and in the clusters that we're currently operating in, because we've taken this cluster by cluster - and when I talk about clusters, Wagga is one cluster. Deniliquin is a cluster that includes places like Barham, Moulamien, Berrigan, Finley, those areas, and they all feed into the Deniliquin. We've got that in the two clusters currently operating. They then see those patients on that patient flow portal and the team look to have a case conference with the providers of care, and that is mainly around an ED workforce person from the ED, a community nurse, it could be a physio, depending on who is being involved in the care and what the presentation is. And they look at how can we support the person to receive the care that they need rather than presenting frequently.

Q. So is the 10 presentations to the same ED or can they be across multiple EDs?
A. It can be across multiple EDs.

Q. Just within the district or statewide?
A. My knowledge is just within the district but I might have to check that, so, yep.

Q. Once the particular needs of the individual patient are identified, I take it that the multi-disciplinary team that you've described is selected to meet those needs; is that right?
A. Yes. So depending on what the presentation, presenting problem, is - and they are all somewhat different - there is a number of - we see chronic disease as obviously one of the higher presentations. We will see people with co-morbidity around mental health, drug and alcohol, in this cohort; diabetes is chronic disease, obviously; and some degenerative disorders.

So essentially, they're the types of people that we see mostly. We can see that. And then, depending on that particular patient's presentation, that is how we would then decide on who would coordinate the care and who we need around the patient.

Q. And what might that look like?
A. So integrated care coordinators exist across the district. So they're dispersed and they're from our service, so Murrumbidgee employees this group of people.

Q. How many are there?
A. Six. And then - we have six community positions and we have three, roughly around just over three, integrated care positions as well. So nine in total. And in that, we have those dispersed across, as I said, however, we use virtual technology as well, so just because someone's based in, say, Deniliquin, doesn't mean they can't help out in Wagga, or if they're based in Tumut, it doesn't mean they can't help out.

Virtual technology is a big part of that program. So essentially, if someone, a patient, comes through, they are assigned one of those integrated care coordinators to basically do a deep dive into their care that they've received in the district, and then work with the patient to look at what other services they may be using outside of the district, and then look to provide support, what support is required for them in terms of how they manage their care, and a lot of it could be social care as well.

Q. When you say they do a "deep dive", how is that done?
A. Into the electronic medical record.

Q. And that's just records within the district; is that right?
A. It is, it is, until we --

Q. Does it extend to others?
A. Yes - only with patient consent. So once they start working with the patient, they then have more flexibility to start looking at, you know, what other services have they accessed.

A big part of the integrated care coordinator's role is to go with the patient to their GP, if they have a GP. Many of these people don't have a GP, for a variety of reasons. Part of that is then going to their GP and working with the GP and, therefore, that opens a door to accessing a number of other opportunities for the patient.

Q. And for those patients who don't have a GP, what's the role of the integrated care coordinator?
A. So for those people who don't have access to a GP, the integrated care coordinator, one of their roles is actually to align that patient with a GP close to their home and we also - there may be, in the interim, a short period where they won't have access in the interim, but they need the access, they need the services of a GP. We will utilise either virtually or in person our GP VMOs in our rapid assessment clinic to provide that very short-term relief in that space, until we then connect with a GP in their community.

Q. And the rapid access clinic is the service run out of the Wagga Base Hospital; is that right?
A. Correct, yes.

Q. How many patients are currently within this program?
A. So in Deniliquin, for the last 12-month period, we've had 20 case managed, so a very small amount. And in Wagga, 132 patients in the last 12 months. Noting that the denominator is far bigger, they're a very small proportion of who is flagged on the patient flow portal.

Q. When you say it's a "small proportion", is that a matter of resourcing?

A. Yes.

Q. Funding?
A. Yes.

Q. How is it funded?
A. It's funded in a mix of permanent funding through the 3.6, which is integrated care funding, that's permanent, that's recurrent. The six FTEs funded until June 2025 through the enhanced community care funding. That - the funding is exactly that, it's - that is the reason why we have such a small percentage, yeah.

Q. As part of the wrap-around service that you described, you've mentioned GPs, specialist services, allied health. Are there any other agencies that might be engaged as part of that process?
A. Yes. So other services might be corrections, NSW Ambulance, and one of the other referral pathways I should have noted earlier, too, is NSW Ambulance. 90 per cent of EDC patients come from the patient flow portal, 10 per cent come from a direct referral from NSW Ambulance of frequent presenters to their service as well. So 10 per cent come through that pathway.

Q. Those are people who are frequently calling the ambulance service for assistance?
A. Yes, yes.

THE COMMISSIONER: Q. Can I just follow up something you said a couple of answers ago?
A. Yes.

Q. You said, "in Deniliquin in the last 12 months we've had 20 case managed"?
A. Yes.

Q. "In Wagga, 132, noting that the denominator is far bigger"; what does that mean?
A. What I mean is on average, and we're just in the process of going to evaluation with the EDC, but we're able to look at the patient flow portal each day and see how many people are flagged as eligible for this program, and it's around 5 to 8 per cent we pick up.

Q. I see. And then you were asked, "How is it funded?" And you said, "It is funded in a mix of permanent funding

through the 3.6", which might - is that technically 3.84?
A. Yes, sorry, yes. Sorry.

Q. That's all right. Don't worry about that - "which is the integrated care funding, that's permanent, that's recurrent"?
A. Yep.

Q. "Then the six FTEs funded until June 2025 through the enhanced community care funding" - so that's NSW Health funding?
A. It is.

Q. But it's only temporary?
A. Temporary funding.

Q. Does that make it difficult to attract those staff, those --
A. Yes, yes.

Q. -- people?
A. Yeah. Yeah, it's --

Q. You can't guarantee a position after --
A. No. So temporary positions will always remain challenging to fill for obvious reasons. Yes.

Q. And you went on and said "that - the funding is exactly that, it's - that is the reason why we have such a small percentage." So by that, that gets back to the answer you gave about denominator - that is, that your funding isn't sufficient to take up all the people that would qualify for the program?
A. Yes, correct. Yes. And that's why we've taken that approach, cluster by cluster by cluster.

MR GLOVER: Q. Do you have a sense of how many First Nations people might be part of this program?
A. Just over 30 per cent. Just over 30 per cent identifying.

Q. Given that the issue that the Commissioner has explored with you a moment ago, the numbers who can be taken versus the numbers who might qualify, do you have any sense of the numbers of First Nations people who might qualify but at the moment can't access the program?
A. That's a good question, but I just can't - so the

denominator of the total, I'd have to take that on notice, yes.

Q. In delivering the program in particular, in the context of First Nations patients, is there any work being done with the Aboriginal controlled community health organisations?
A. Yes, so this team works really closely with RIVMED, which is in Wagga, and GAMS, which is the Griffith Aboriginal Medical Service. We can and we have provided services within those areas over the years, so we can go to them and provide that service.

I note in the last couple of years with RIVMED there was quite a strong - here in Wagga, quite a strong connection. Then there was some disconnection there, for whatever reason, but then in the last, say,12 months that's picked up again with RIVMED, so quite good connection there.

Q. When you say you work closely with RIVMED and you mentioned another in the Griffith region, which I didn't quite catch, which is --
A. GAMS.

Q. GAMS?
A. Which is Griffith Aboriginal Medical Service.

Q. Thank you what is being done in that work?
A. So it depends on what level. I suppose from an executive level, you know, we have them as part of our, you know, regular - we work with them at an executive level as well, but in this particular area of EDC, those particular clinicians can and will provide services as required into the Aboriginal medical services. So they can see patients in there.

And if we just flip back to collaborative commissioning, that's something that Griffith Aboriginal Medical Service and collaborative commissioning have done really well. We've even run one of our outpatient cardiac clinics at the AMS in Griffith. So the overrepresentation is really important for us to acknowledge that, yes, we need to work closely with those partners.

Q. Is there anything that can be done, in your view, to improve the success of that work with either RIVMED or

GAMS, by way of example only, to service the needs of the First Nations population?
A. I think we need to continue to strive to do more work in those AMSs, so we go to them, as opposed to them coming to us. So I think we need to continue that in these programs, as in we need to make that, you know, more of our BAU, and taking the care to people. That's something I think that we could strengthen.

Q. And is there consideration to how to present these programs in a way that might be culturally safe for First Nations people?
A. Absolutely. And we do work with our local Aboriginal health teams, and our LHD Aboriginal health team, around how we do that. So before we go and do any of this work, work is done pre that with our LHD Aboriginal health team to ensure that we are appropriately - working culturally appropriately with these people as well.

Q. Back to the issue of funding. To the extent that there are outpatient services delivered to patients on the EDC program, do they attract activity based funding?
A. So the NWAU? They do, and one of the complexities with the EDC - sorry, yes. The answer is yes. I'm going ahead there.

Q. You've anticipated my next question.
A. Yes, I did. Sorry, my apologies.

Q. Does that give rise - I'll just use your word. Does that give rise to any complexity in your view?
A. Yes. So these new models of care, where we're talking about multidisciplinary teams working with one patient, they're innovative. As I said, we know that they are successful, we've seen the reduction in ED presentations. However, they do give rise to some complexity in funding, and one of them with the EDC that we have noted is that if we have this particular team, or just let's say one person, so one person in Wagga is seeing one patient in the morning, and it might be that they go into the ED because that's where they are, they go into the ED and they see them there, that activity gets captured into the ED. They then go back to the community setting because they are going to have a one-on-one with that patient in the primary care setting with the GP. That's counted as one activity, one occasion of service.

However, then they might go and organise a dental appointment for that same patient or they might organise something with another social care provider. That gets wrapped up into what they call "one service event". And that is one service event for the day, even though there have been three or four interactions for the patient. So that's one complexity. We're working with the Ministry of Health on that.

Q. Just pausing there, what is the result of that complexity from a funding perspective?
A. Well, it's underfunded because there could be three or four episodes of care, occasions of service, to use the terminology right - and I'm certainly not an expert in funding terminology but that's what they call an occasion of service - we've had three or four for the day, and for that particular program it looks like we've had one service event that attracts - goes into that NWAU funding.

Q. So in the context of that program, the ABF construct does not enable, or readily enable, the entire service to be captured as delivered as opposed to how it might be classified; is that right?
A. It doesn't acknowledge complexity.

Q. Is there any other issue that you were going to raise before I interrupted you?
A. Only, I think, you know, that these programs, as I said, they're very innovative models, they're very new, however, it's a really good example of the system having to catch up with some of that, those funding mechanisms and how we look at outcomes. So I think for these programs, we know they work well, they - patients report, and that's in their outcomes, that this is something that they have great outcomes on. However, for us to truly recognise the value, we have to be able to look at the complexity and fund complexity.

Q. A couple of times in those answers you have described this program being "innovative". This is the EDC program?
A. Yes.

Q. What do you consider to be the real innovation in it?
A. The real innovation is that we cross - we're innovative because we cross those, I would say, traditional silos of acute, primary and we pull all the health players together, even the transports and your social care

providers, which are becoming so much more important in the health space, social care.

We know that the majority of people, when they're coming in to an ED, we see one episode of what they're presenting with. However, when these EDC programs go and actually sit with these patients and understand what they're facing, it's the social care arm and aspects of their lives that are often the most complex and needing support.

So the innovation is that EDC is straddling all of that, and they're saying, "How can we case coordinate with you to support you to get what you need in the right time that you need it from the right provider?"

Q. Is there scope for that type of approach in other areas of the delivery of healthcare services outside of emergency department presentations?
A. Look, it's gold standard, and we did see this in COVID as well. We did this really well in COVID. You know, we worked with - I can only talk from our Murrumbidgee primary health - LHD and primary health network.

We put a primary health network employee into our COVID team and patient flow team, and that same premise we - they were there to support and connect the primary care setting to what we were doing in the acute space. So I think it's pretty simple, but it's still innovative in that regard.

Q. That's an example of a local response to the challenges presented by the pandemic. Is there something the system can do to enable those types of approaches to be embedded in the way that health care is delivered?
A. I think the - looking at those funding models coming out of Commonwealth and state and how we fund these programs, and that then will naturally cause a bit of siloing. However, the other part is around the single digital patient record. So that may go some way, then, to supporting that capacity to have - have fragmented patient records.

Q. Has there been any assessment done of the success of the EDC program?
A. Locally we have, so we've been able to look at our clusters and look at the measurement of ED reduction. So

that's in its early stages, and that's - and I have to stress that is local. So we have seen in Deniliquin with those patients a 54 per cent reduction in ED presentations.

Q. When you say "a 54 per cent reduction", how is that measured?
A. So we measure throughout that - the previous 12 months and we look at the next 12 months and --

Q. That's the presentation of the patient cohort in Deniliquin in the previous 12 months?
A. Yes.

Q. And then after their engagement with the program?
A. Yeah.

Q. And what has the result been?
A. 54 per cent. So we have seen that reduction, so they have on average - we average it out over the people in the cohort that we're measuring. But in Wagga, we've seen a much bigger reduction of 78 per cent of - because we have a bigger group of people in Wagga that we can measure against.

Q. That's a measure of presentation to the ED?
A. Correct.

Q. Has there been any measurement of the health outcomes for those patients?
A. Yep.

Q. How is that done?
A. So we currently use a patient reported outcome measure, which is a PROM. We use - I mean, it's probably not - it's a tool that we use to - we ask a number of questions, and we ask that at the beginning, middle and the end of their care in the EDC.

Q. Let's just step it through. How are those questions asked of the patient?
A. Yep. So an example might be, as a PROM, and it's a tool that we uses, so it's a predetermined tool, and in that, it might be: how is your sleep, how is your eating habits, how is your access to a particular service? That's measured at the very beginning. Clinicians locally use that tool as a way to support the patient through the program. So then it's again measured at three months or -

there could be midway, but three months is usually another measurement time. And if there has been an increase or decrease, that then forms part of how they provide that care moving forward. So it might be that since engagement with the program, they may have rated their sleep habits as fairly - very poor, for example, and that at three months we're seeing that they're now, you know, rating them as good. So we're using those outcome measures all the way through the patient's journey.

Q. So the questions remain the same and they're measured each time?
A. Yeah.

Q. Are these a standard set of questions or are they tailored to the patient's presentation?
A. No, they're a standard set.

Q. And has there been any data collected about how the patients have recorded their PROMs throughout their engagement with the program?
A. We only - what we do is we - what we collect is how many times the patient has been offered. So we record that in the file, and we record that at a local level, and at a state level they collect a higher volume. So a volume - they look at the volume of how many people were offered and how many people provided a response.

Q. What about analysis of the responses? So that, take, for example, "How was your sleep", at the start, versus "How was your sleep" at the end --
A yes.

Q. -- is there any measurement done of those types of criteria to determine the success or otherwise of the patient's engagement with the program?
A. So in terms of that, that is very much around - that's used as a patient journey, so - and measurement for the patient and the clinician, and it's outcome driven. So it's about, then, how do we utilise that as part of the care we provide: do we need to increase it there, do we need to pull it down there? And then as part of the evaluation for EDC, which we're just about to do with the ministry, that will form part of that as well.

Q. When you say, "that will form part of" the evaluation of the EDC, which part of the PROM are you referring to -

the number of patients who have engaged in the process or the reported outcomes?
A. The reported outcomes and the number. So both. So volume and patient outcomes. So that's the evaluation that we're proposing. It's very early. We've just started the remit now, yep.

Q. Is there another measure that's used as part of this process?
A. The other one that we look at is PREMs, which is the patient experience. So how does the patient experience - and that's more at a - that's anonymous. That is something that patients are offered. I can say that 100 per cent of patients are offered the PREM, and the uptake is much lower.

Q. What sort of questions are they asked in a PREM?
A. About how they experience their care. So did they feel safe, did they feel that they were offered, you know, enough time, all that. So - yeah.

Q. Has there been any collation of the data of those responses?
A. Not at this point with PREMs, no.

Q. You mentioned in an earlier answer that there's a review of the program that's about to be undertaken. That's by the ministry; is that right?
A. In partnership with --

Q. Partnership with who?
A. Us and the ministry. So that's something that we're just starting that process now.

Q. Are there criteria for the measurement of the performance of the program or is that something that's currently in development?
A. Currently in development, yes, yeah.

Q. When is it anticipated that the process will kick off in earnest, do you know?
A. I couldn't give you a hard date on that. As I said, it's in the proposal stage. So - yeah.

Q. I think you may have been here for part of, at least, Ms Manzie's evidence earlier this morning.
A. I was.

Q. And I'm asking these questions in the context of your interim role, which - how long have you been in that role?
A. About two months now, yes.

Q. I'll ask you some questions, and you tell me whether you're in a position to answer them?
A. Sure, yeah.

Q. Ms Manzie gave some evidence about a gap, what she considered to be a gap, in mental health and drug and alcohol services between, on one end of the spectrum, those who are in need of acute hospital admission --
A. Mmm-hmm.

Q. And, on the other, those who are capable of being managed in the community --
A. Mmm.

Q. -- and the gap falling along the spectrum in between, that gap being through a lack of services or a lack of access to services. Is that something that you are familiar with in your work?
A. Certainly from an LHD perspective, we are definitely geared towards the more higher acuity for mental health presentations. That's absolutely our area of expertise, I would say, you know, and that's where we - and we've also got the now higher-end community programs.

THE COMMISSIONER: Q. I think Ms Manzie said she felt that there were enough beds for acute patients.
A. Yeah, yep.

Q. Perhaps before Mr Glover asks any more questions along this line, most of the questions you've been asked, in fact, all of them until now, have been in relation to your role as the director of integrated care.
A. Mmm.

Q. In this interim director role, regarding mental health and drug and alcohol, what does that actually involve in that role that you've taken, the interim role? What do you have to do?
A. Yeah, so very similar to - similar in terms of that strategic oversight for mental health, drug and alcohol. So lots of stakeholder engagement, working with our partners. You probably would have heard from Robyn around

the extensive stakeholders involved in how we deliver --

Q. Are you the representative in the alliance meetings?
A. Yes, I am.

Q. You are?
A. Yes, I am. I've been to a number - just a couple of those meetings in this period. So I'm familiar with that. So part of the role is around how we manage our resources and, yes, it's inpatient setting, but also community setting, and the delivery of those. Yes.

MR GLOVER: Q. Perhaps leaving to one side for the moment the acute patient needs, even in your work in the integrated care space and delivering some of the models that we've spoken about, I take it you have from time to time occasion to consider the availability of mental health and drug and alcohol services within the region?
A. Yes.

Q. What is the availability of those services within the community within the region?
A. We have as - availability for us is around looking at - so we - with the alliance, there's a number of providers in our district, as you would have noted earlier. It's about that stepped-care approach for mental health. So we have that higher acuity, as I just spoke about, with the district, but we also have providers in the community that are what we would say is that mild to moderate and care coordination and social care providers.

I think there's always room for, you know, more, and certainly we always try - that's part of our role in the alliance, is that we work together to look at where are the gaps or where do we need to step up. And whilst we do have a number of, you know, pathways, it's important to note that not everyone can provide everything to everyone. So the district can't provide the whole spectrum of services and we don't expect to, but we should be engaging our stakeholders to ensure that we are working across the spectrum.

Q. The "we" you used in that answer, is that "we" the district or "we" the alliance", or "we" as healthcare providers?
A. We the district. We the district, so we acknowledge that, you know, we don't deliver everything to everyone, we

deliver what we deliver. However, it's still - we also need to be also cognisant and planning across the spectrum as well, and I think that's quite a unique thing for Murrumbidgee, though, the relationships that we have with the alliance, so that alliance that is built.

I don't know if Robyn spoke about the local response group for suicides that happen in our district and how we come together as a group to plan around that person. So these are very unique programs, for want of a better word, or initiatives, to Murrumbidgee.

Q. What you're describing there is an approach within the region of the district and other stakeholders collaborating to, as best it can, eliminate the gaps of the kind that I raised with you earlier; is that right?
A. Yeah, and wrap-around care for what's needed. So yes, looking at gaps and what - who's traditionally providing those services to a person at that particular time.

Q. Does the divide between Commonwealth funding sources and state funding sources provide a challenge to achieving that aim?
A. It does. However, this - this is where early on in my evidence that I talked about the PCCG, which is that governance group for the PHN and the LHD. They have brought in the Head to Health, which is mental health services for Wagga and Young - that's a newly established service - into that PCCG governance group to ensure that we're working together and collaboratively, that we are not working in silos and, therefore, fragmenting. So that's one way to do that.

Q. Can you just tell us a little about that program?
A. So essentially we've got headspace, which is 12 to 25 years of age. This is for people outside of that predominantly. It will be set up in Wagga and Young. It's still in the set-up stage, so - yep.

Q. And why was it identified as a need within the region?
A. It's another part of the care pathway for people who require mental health services that don't fit into the current programs that we've got, which are, like your headspace and our mental health services and other care providers in the district, so - it does operate across a number of other areas, but for us, it's going to be Wagga and Young.

MR GLOVER: Thank you, Commissioner.

THE COMMISSIONER: Q. Can I just get your opinion - and this is whether you agree or not. I think what Ms Manzie was getting at - one of the things she said was there could be better coordination of the funding.
A. Mmm.

Q. But I think her main point on the area that Mr Glover was just exploring was for people with serious mental health or drug and alcohol issues, but not to the extent that requires admission, so not acute care but serious --
A. Yep.

Q. -- that's where there's an underfunding, which creates access problems, strain on the providers of the care and therefore the combination of those two leads to less than optimal health outcomes for people needing those services. Do you generally agree with that?
A. I do generally agree with it, and I suppose, you know, in full disclosure, I'm a psychologist, I do - and I've had 20 years of experience in this area, and I can certainly say that people don't come with a one presentation. The co-morbidities that people have that they present with, that is the complexity, and often, programs are only funded or built to deal with the one presentation, so they go off to that.

What we need is to be looking at their whole presentation in a holistic approach. You know, at risk of sounding like I'm harping on about it, but programs like EDC and collaborative commissioning, they are the real programs that are tackling some of this, and they're not the only ones, there are other programs in mental health that support that as well, like the Pathways to Community Living, a very similar approach to EDC, they wrap around patients and look at how can we support them outside in the community, and also address their social care issues, because if we're - that's the biggest issue we're facing right now, is social care issues and providers. So I think where there is co-morbidity, there is complexity.

Q. Define "social care". I think I know but I want to make sure.
A. Yeah, sure. Homelessness, domestic violence. We see a lot of the people in hoarding and in, you know,

situations like that, people who are living on their own with no supports. Frailty. All of that. So what we would call as traditional social care issues, that's where we - that's where we need a bit more of a holistic approach, because we know that those social determinants of health have a massive impact.

THE COMMISSIONER: Thank you. Mr Chiu may have a couple of questions for you.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. My name is Hilbert Chiu and I represent NSW Health in this Inquiry.
A. Mmm.

Q. Earlier on in your evidence, you referred, in the context of collaborative commissioning programs --
A. Yes.

Q. -- to this idea of realigning existing funding --
A. Yes.

Q. -- as a way of securing funding into the future?
A. Yes.

Q. For those programs?
A. Yes.

Q. You recall that evidence?
A. I do, yes.

Q. Can you give us an example of what might be a realignment of funding?
A. Sure. Yep. Sure. So one may be in that we have utilised our community nurses to be able to focus their efforts on chronic disease more so and care planning around those chronic disease cohorts of COPD and CHF. That is actually not out of their remit, because those two conditions, we already know through population data that that is a big concern for the Murrumbidgee, that people who have those two areas of chronic disease, we know that we have really high preventable hospitalisation in those areas. So our community nurses, we have upskilled to work around care planning for those particular areas.

Other alignment might be --

Q. Just pausing there --
A. Yes.

Q. -- using that example, those community nurses are already funded?
A. They are.

Q. For your existing activities?
A. Correct, yes.

Q. And what you're doing there is expanding or redirecting what they do?
A. Yes, yes. Many of them have these patients anyway, but they're seeing them in an episodic type of way prior to collaborative commissioning. So we utilise some of the funding to upskill this staff cohort to provide specific care planning services and support to these patients.

Q. I think you were about to give a second example there, if I interrupted?
A. Yes. So one of the other examples might be that we - I know - and this is more sort of sitting with the PHN but they - you know, and maybe this is something you could ask in evidence there, but certainly around the PHN - look for opportunities through MBS billing.

Q. I see.
A. Yes. So in general practice, they would look to have alignment or realignment of some of these occasions of care, and we talked about this in the incentivisation of GPs around our winter strategy. There may be some opportunity to realign there.

Q. Do you mean there, helping GPs work out ways --
A. Yes.

Q. -- to use the Medicare scheme?
A. Correct.

Q. So that they bill sufficiently for their complex work they're doing?
A. Yes, absolutely, yeah. And obviously there is Commonwealth funding available to the PHN that they can use for incentivisation as well. So it might be block funding amounts as well.

Q. From the perspective of the LHD, is all of the funding needed for collaborative commissioning programs - can all of that be covered by realignment of existing funding?
A. The ethos is that it should show a reduction in inpatient activity, acute inpatient activity, that then has an impact on the funding required for that. So it should be self-sustaining, yeah?

Q. So the plan is, in the long run - and it could be a very long run --
A. Yes.

Q. -- it will pay for itself, as it were?
A. Yes. So that's the notion. However, the challenge is that three years is a very short time in reality, and we know that because we've implemented and we've had challenges along the way, and it can be workforce challenges that we can't get those health professionals that we need, so we have to go back to the drawing board and we need to look at a different way of delivering that care pathway.

THE COMMISSIONER: Q. When you say years is a "short time", it's a short time to evaluate both better health outcomes and what's happening in terms of funding --
A. It's a short term --

Q. -- costing, yeah?
A. Yeah. So we're getting three years in collaborative commissioning to fill these gaps and deliver these pathways. However, what we need to remember is we need to have flexibility in that system, because we know, for example, we planned that we would hire, you know, and employ certain professionals. That hasn't happened for various reasons which we're all aware of around the workforce challenges. We need to go back, and which we did, but we have a different way of delivering that particular pathway - same care pathway, but in a different way, but that will lengthen that process, and then exactly what you just said, it is going to take a little bit longer to actually see the biggest bang for buck in this program, because for us to see the real value of this, it will take a little bit longer --

Q. You are dealing with chronic conditions?
A. Absolutely. Absolutely. And turning the needle - we're just coming off the back of a pandemic as well. So

there's a lot that - you know, there's a lot that we need to consider.

MR CHIU: Q. And while - in the meantime, while we are waiting for the bang for buck to show itself, and that could be some time, does any cost that is not covered by either the Commonwealth or by realignment - that has to be borne by the local health district?
A. It does, yes. Yes.

Q. And that is something the local health district is committed to doing?
A. Yes, look, we are - what I will say is this: collaborative commissioning, we're developing local - we've developed local pathways for local people in this community where there are existing gaps, so how can we not continue to do that? That is something that we should always strive to do.

THE COMMISSIONER: Q. And you have confidence in - the LHD has confidence that these things are going to at least improve health outcomes for the people in your population that have these chronic diseases?
A. Absolutely.

Q. And that's based on expert advice from the clinical advisory group, amongst others, no doubt?
A. Absolutely. And you know, we're engaging with these professionals and providers at all points and we are using that PROMs data as well in this collaborative commissioning, and we've actually implemented it in GP practices, so we've engaged our GPs to say, "Hey, we want you to use the PROMs, the outcome measures, as well, to tell us how this is going." We're very serious about how it is actually having an impact.

So I think, you know, certainly in my time, this has probably been one of the programs that I can say, hand on heart, that you are actually seeing some real benefit to communities who have never had access to these services, rural communities; they've never been free to access, and there is an equity issue in itself. So for me, this is really showing incredible, you know, outcomes for that reason, yep.

MR CHIU: Q. One more issue, if I could ask you on that, you referred to a process of consultation with important

stakeholders in the community?
A. Yes.

Q. This is for collaborative commissioning programs - both at the conceptual stage but also throughout the rollout?
A. Yep.

Q. And you referred also to engagement with GPs in the community?
A. Yes.

Q. Can you give us examples of what that engagement might look like?
A. Yeah, sure. So it can be anything from a - in the initial start-up phase with the collaborative commissioning there was a number of GP forums, like lengthy forums undertaken with GPs to develop the pathways, first of all to understand, you know, how big is this problem, what do they need? Because things like winter strategy and the work we did with pharmacies, they don't just come born out of our, you know, work, this is done in collaboration with those partners, saying, "This is what we would need", alongside some of the research that we have.

Q. So forums; anything else?
A. Forums; meetings, we have our - which we just spoke about - clinical advisory group, our GPs are on that clinical advisory group. That's an ongoing advisory group, so that's just part of the collaborative commissioning all the way through, and that is a forum for all - a number of issues to be raised and resolved and take direction from our people in there. So we have that. Obviously we have our PHN who we work with on all of those platforms that we spoke about. They engage GPs through their processes. So we will often go to the PHN to request a particular area for resolve, mmm.

Q. From your perspective, having been involved in these programs, do you get any sense that the GPs feel they are not consulted with or aren't collaborated with in these programs?
A. Look, probably with collaborative commissioning it's not a great example, because they are, and it's probably one of the most, you know, engaged programs that we have. So certainly we often attend their practice - they have practice, group practice teleconferences as well, so we'll

often go into there and deliver any information that we need and talk with them about - through those processes. I think certainly we have - there are always challenges across a number of our other areas that we need to probably engage further with GPs. I think that can always - we can always do better at that. And that's something that, you know, we continue to work on.

MR CHIU: No further questions.

THE COMMISSIONER: Thank you. Did anything come out of that?

MR GLOVER: Just one issue.

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. In some answers to the Commissioner, you mentioned that part of the collaborative commissioning pathway was to address gaps in services that are available?
A. Yes.

Q. Gaps in primary health care that you have in mind?
A. Yes.

Q. When we look at those who are involved in the EDC program, are those patients who are presenting because of a gap in primary health care?
A. Absolutely.

Q. Whether because of a lack of access, firstly --
A. Yes.

Q. -- or that they just haven't accessed it?
A. Lack of access or haven't accessed it or have become, for a variety of reasons, unable to access a GP. They may have become very complex and, you know, for whatever reason, that is not then - they are not able to access a GP for that reason and they need a little bit more of a coordination to their care, and then we introduce them back in. But essentially, the biggest cohort is that you won't have a - they won't have a GP. Yes.

Q. And in addition to that, some of those patients have other social care needs that you have described?
A. Yes, yes.

Q. And those patients presenting typically haven't been able to access those services?
A. Yes.

Q. And is that part of the EDC program, that the district is, in effect, stepping in to provide access to primary health care on the first point?
A. We case coordinate. So it is a little bit different. We don't provide the primary health care, as such. We do for that small amount of time that I said to that small amount of patients who don't have access to a GP, because, remember, the first priority for us is to link them in with a GP. So that's our first priority. So where they live - and it might be the Deniliquin cluster - we work with a number of GPs, and these are - these clinicians, when I say these integrated care coordinator clinicians, they are very familiar with our primary care providers, they are working with them day in, day out, they know where they've got some capacity to take on new patients, maybe, so that happens on a regular basis.

Q. So they are assisting those patients to access --
A. Primary care.

Q. -- primary care, specialist care --
A. Yes.

Q. -- and social care?
A. Correct.

Q. And that is being funded by the district?
A. Yes.

MR GLOVER: Thank you, Commissioner.

THE COMMISSIONER: Thank you. Thank you very much for your time and your evidence. We are very grateful.

<THE WITNESS WITHDREW

THE COMMISSIONER: Do we adjourn until 2 or 1.50, what do you want to do?

MR GLOVER: 2 o'clock.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Good afternoon.

MR MUSTON: Afternoon. I call Dr Nicholas Stephenson, S-T-E-P-H-E-N-S-O-N.

<NICHOLAS STEPHENSON, sworn: [2.00pm].

THE COMMISSIONER: Mr Muston will ask you some questions.

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Stephenson, you are a radiologist working in Wagga Wagga?
A. Correct.

Q. I think you are currently the senior radiologist (clinical director) for IMED Riverina?
A. That's correct.

Q. How long have you been practising as a radiologist in Wagga Wagga?
A. About 28 years.

Q. What roles have you had during that period? Have you always been with IMED or were you in different roles?
A. Originally I was in a private practice that was privately owned, and I was one of the owners of that practice, and then we sold to the corporate group, but at the same time, we also provided services to all the hospitals in the Murrumbidgee Local Health District formerly the Greater Southern Area Health Service, and so on, which included Wagga Base, Griffith Base and all the small hospitals in the district.

Q. Was that as a VMO --
A. A VMO, that's right.

Q. -- working in different hospitals?
A. And also provided services for BreastScreen NSW.

Q. Did you have a connection with Wagga Wagga before you commenced working out here?
A. Well, actually, I had been a resident here and a registrar during my training but you obviously have lots

of such positions over the course of training time, but I grew up in Bathurst, so I was a New South Wales country kid, if you like.

Q. Was it that rural or country origin that attracted you to work in Wagga Wagga?
A. Well, certainly it was a decision of my wife and I that we would work in a regional/rural centre, despite the fact that, you know, I obviously did my medicine in Sydney and trained in Melbourne and overseas centres, but, yeah, it was a lifestyle choice that my wife and I made together, and luckily I had a wife who had the same aspirations as me.

Q. I think until 2020, you were also the conjoint associate professor at the University of New South Wales, in the Riverina medical school; is that right?
A. Yeah, that's right. So that was an unpaid position, conjoint position, that's right. I think it was in recognition for all the teaching that I've done over the years with students and facilitating, you know, their sort of radiology exposure and so on, and, yes, so that's - yes.

Q. So in terms of the teaching and training that you've been involved in, at a practical level, could you explain to us briefly what that has involved over your 26 years in Wagga Wagga?
A. Well, from the medical school side of things it was when the - what the rural clinical school first started, the University of New South Wales. It was first a rural clinical school and it's recently become the medical school, they wanted some radiologist involvement. There was no curriculum or resources as such, available, apparently. So I created lecture notes and created a whole lot of PowerPoint, like, tutorials in various sort of elements to sort of match what the base curriculum was.

Q. This was for undergraduate students?
A. This was for undergraduate students. And then I provided most of those tutorials, but I also encouraged some of my colleagues to get involved and at the same time we got the students to come into our practice and also into when we were working at the radiology department at Wagga Base, always feel welcome but also just spend structured time there where they'd learn how to do some ultrasound, they'd see how x-rays were performed and various procedures. So it's a combination of experience and

tutorial type sort of stuff. Then they had the lecture notes, which included references that they could sort of further assess.

Then, in terms of, then, those junior residents that, once they've graduated and they're working at the hospital, I was involved in the education of them, some radiology, and also, you know, encouraged them to come down to the department whenever they had patients there to engage with us and we could teach them about or tell them what was happening with their patients and get involved in their care.

Q. So that was junior medical officers - is it a structured form of education that they're receiving through you or is it more of a process of osmosis?
A. Yes, it's - mostly osmosis, but there were, at various times, sort of lecture/tutorial type things. There'd be lunchtime lectures or something like that, as well as various meetings where, we'd say, let's say, have a fortnightly surgical meeting of imaging. So I would go through the imaging and, you know, at the same time as answering the clinicians' questions, the consultants' questions, you know, structure it so that those medical students there, those junior doctors there and those training doctors there, could understand what I was talking about. So it was a combination of all of those things.

Q. What about vocational training, specialist training of radiologists? Is that something you have been involved in?
A. Yes, in Wagga. Yes, very early on I tried to get a radiology accredited training position here in Wagga, but the college unfortunately, you know, let us down in that regard.

Q. Can I just ask you to pause there. When you say the college let you down, what was the blockage, as you understand it?
A. Yeah, okay, so just briefly, the branch education officer at the time was fully supportive of us creating a position. We had offered a position where we would pay salary and all on-costs, plus some travel and accommodation.

Q. When you say "we", are you talking about your private practice or the LHD?
A. My partners in the private practice - if one of the

teaching hospitals in Sydney would just add an extra registrar to their roster. So the branch education officer organised a meeting of all the heads of departments of all the Sydney teaching hospitals where there were accredited trainees, as well as those in Newcastle and Canberra, and we had a long meeting, where, essentially, all those heads of department just torpedoed it because, you know, in their eyes, their trainees had mortgages or kids in schools or that we would just abuse the trainees.

It was incredibly offensive, their attitude, and I've met it subsequently when I've worked with IMED to try and get network training in New South Wales, but eventually I was successful and enough people in the college understood that we needed to have at least some rurality to the training networks, and there is now.

And then for about seven years we did get a trainee here, an accredited trainee, as part of the LAN 3 network, we originally were paying the salary and all on-costs, including two return air flights during their six-month term and we paid for accommodation.

We eventually got some Commonwealth funding for their salary which covered most of those costs. But unfortunately, we kept on getting sent all these juniors who were metro based and then, as we lost some radiologists in our own workforce, it became untenable to continue, unfortunately.

I also started a radiology RMO position at Wagga Base Hospital, it was one of the first in Australia, and that sort of then allowed doctors who were either interested in doing other careers to have some exposure to radiology where that was relevant, and also allowed some junior doctors who wanted to do radiology to get that exposure, before they sort of then applied to get on the program.

Q. Can I come back to that in a minute. You had the perception or were told at the time that you were trying to set up the training place that setting up a place in Wagga would in some way threaten the ability of metro-based trainees to pay their mortgages; is that - have I understood you correctly?
A. Yeah. It was unbelievable.

Q. How could they literally think that might be the case?

A. Well, as I say, it was offensive, you know, and the fact that they had kids in schools as well. I mean, the fact is Wagga Wagga had had trainees in surgery and physician training and all sorts of trainees for years, if not decades, and they coped with the fact that they were seconded, as I was when I was a surgical registrar for one year. It's what you do, you know?

Q. So the issue was the trainees who were going to be sent to Wagga, it was perceived that that would in some way unsettle their personal or financial lives in a way that was disadvantageous to them?
A. Yeah, that was it. And also that we would not offer the level of supervision and training that allegedly they would receive in these hospitals, in the major teaching hospitals, but I mean, there's a whole lot of cultural stuff there.

One of the heads of department said to me, "Nick, we're not interested in training radiologists for the whole of New South Wales. We're only interested in training radiologists for tertiary referral hospitals." You know, it's a sort of a - it's a huge cultural sort of gap that existed then.

Q. So I think the proposal was that one of the metro hospitals would take on an additional registrar?
A. Correct.

Q. Was that on the basis that one of the registrars in rotation at that hospital, or as part of that hospital's training program, would be coming out to Wagga to do a portion of their training in Wagga?
A. Correct.

Q. But they would be officially aligned with the metro hospital?
A. Yeah.

Q. And training through your private practice?
A. Yeah. And it was at a time, too, when I was naive about - and you know, the evidence hadn't yet been collected, that really what you needed to do was have, you know, a longer period of rural attachment, in other words, you should have probably - probably at least 80 per cent of the whole training should be rurally. It was at a time when we thought "Oh, listen, we can just rotate some of

these registrars around. Eventually one of them will stick." But I now realise, and the evidence shows, that we really need to set up our own program here, you know, and train them from the - select them ourselves, train them from the start here and so on, but anyway, that's --

Q. We might come back to that. Again, just to make sure I've understood conceptually what you've just referred to, is it that you perceive, based on what you've read, that 80 per cent of the training needs to happen in the rural area in order to maximise the chance of retaining that trainee within a rural setting, as opposed to, say, a short rotation out to Wagga for a few months, where they might actually maintain their physical connections, say, with Sydney, but just fly out through the week to do their work and fly back on the weekends to continue that attachment, life attachment, to Sydney?
A. Correct. I mean, you know, there's a wealth of observational evidence showing that the more rural training there is for any particular candidate - and this is observational research - the much more likely it is that those doctors will choose to live and work rurally. That's why I gave those 11 - listed those 11 references which are both in Australia and Canada, and Canada has very similar geographic challenges that we face in terms of where its population is based, and so on, and it clearly shows that if you want to succeed in getting more than 50 per cent of your junior doctors choosing to live and work rurally, you actually have to have a rurally based program not just have them on rotation, so to speak.

Q. Do you have a copy of the outline of evidence that you have brought with you?
A. Yeah, I do.

Q. Where you referred to those 11 journal articles, if I could invite you to turn to page 6, which is appendix A?
A. Yeah, appendix A, it has the 11.

Q. It's appendix A to your outline which lists the journal articles that you've just referred to?
A. Correct.

MR MUSTON: We might, in due course, tender appendix A, Commissioner, just so that we all have a record of what that is.

THE COMMISSIONER: I haven't asked, the outlines we've been using, are they being tendered?

MR MUSTON: No.

THE COMMISSIONER: Okay, this can be tendered if you want to do it now.

MR MUSTON: I don't have a loose copy of annexure A without my scribble on it, so we might do it tomorrow, if that's - and it's double-sided.

THE COMMISSIONER: We can do it in chambers tonight. I won't even mark it for identification yet.

MR MUSTON: There is no need.

THE COMMISSIONER: We can just move on.

MR MUSTON: I'm content to tender it when we have a nice clean one-sided copy of it. I just wanted to make sure --

THE COMMISSIONER: I have it in front of me, though.

MR MUSTON: As do I, and as does the witness, but I just wanted to make sure we were all of the same understanding in terms of what it was the witness was referring to.

Q. Coming back to something you mentioned a moment ago, you told us that you set up an RMO place within Wagga Base Hospital. Could you just explain to us, first of all, what an RMO place is?
A. Sure. So in these larger hospitals, base hospitals, you know, there's - you have a junior medical staff, who are employed by the hospital, their employees, and they're often - you know, there's interns and then they become RMO1s or PGY2s and so on.

So once they finish their medical degree, they need to spend at least one year as an intern working in such an environment before they can become fully registered. During that time they might work in ED or with the surgical unit, a medical unit, rehab, goodness knows where, okay? And what I found really interesting is that there had been, up until about 20 years ago, no RMO positions in radiology, and I thought how strange, because, one, radiology is now so critical to the delivery of healthcare services - there

would be very few doctors that don't order some radiology at some point, so why not have exposure in that critical time after they've got their medical degree - and at the same time, if we want to encourage as many young graduates as possible to do radiology, we should expose them to it so they can see what it's like, and some will fall in love with it and some will go, "No, it's not for me", and move on, which is fine.

Q. This RMO position was an employed position within the hospital that hovered somewhere between being an intern and entering a vocational training program?
A. Correct.

THE COMMISSIONER: Q. It's short for resident medical officer, is it?
A. Correct, yeah. Resident medical officer, that's right, exactly. And so the idea was that, you know, we would just have an RMO, a resident medical officer, rotating through the department for whatever period the rotations were, I can't exactly remember now, whether it was 8 weeks, 10 weeks, 12 weeks or something at a time, and what was interesting was that, you know, you would sometimes get an RMO coming in saying, "Nick, I really value this because I want to be an ENT surgeon. I really want to learn some radiology before I start my ENT training," and that guy is now a radiologist.

But there are others as well, you know, and I mean, even if you want to be, like, say, a country GP, and you have the opportunity to learn how to get some ultrasound skills, and let's say if you want to do some GP obstetrics, and, you know, is the foetus coming out head first or feet first, as a very basic sort of thing, you know, they learn these skills. They learn how to drain fluid from the pleural cavity of the chest using ultrasound, and these are all skills that now don't get taught on the ward. We do them in radiology.

Where in the past you used to do lumbar punctures, you used to be taught to do lumbar punctures on the ward drain fluid from the pleural cavities in the ward, drain fluid from the perineal cavity in the ward, just using some palpation and so on it's now all done under imaging. So we became the de facto trainers of all future doctors in those very basic skills, which could be useful whether they become a physician, surgeon, a GP, whatever.

MR MUSTON: Q. The view was that setting up this RMO position would facilitate that training?
A. Correct.

Q. And potentially capture some of the market of trainees as future radiologists?
A. Correct.

Q. Did you have any involvement in the establishment of the university medical schools out here in Wagga?
A. Yes.

Q. What was that involvement?
A. Well, I mean, when the University of New South Wales rural clinical school first started, I approached the head of the school at the time and said, "Listen, I would be happy to" - and this is all volunteer work, by the way, I'm here mainly talking about my volunteer role or roles, all unpaid. I said, "Yeah, sure, I'll" - you know - "Have you got anyone to do the radiology?"

And then, we'd had the rural clinical school for about 10 or so years and then a group of us, together with the university, decided, well, it's about the time we got the medical school here so that we can get students from day one here rather than have to spend the first two or three years in a metro centre.

So I chaired for 11 years the rural medical school implementation committee of Wagga Wagga.

Q. Who was on that committee?
A. There were Kay Hull, when she was the member, and then she stayed on it when she retired and then Michael McCormack came on as the Commonwealth member; the state member, so Daryl Maguire initially and then Joe McGirr; and at the same time we had Professor Graeme Richardson, so he was a professor of surgery; all locally resident specialists - Professor Gerard Carroll; Adrian van der Rijt, an orthopaedic surgeon; Louis Baggio, who was a former GP, who then did rehab medicine; Richard Harrison, a general upper GI surgeon, I can't remember - that's probably it. And - yeah, it took us 11 years but we eventually got there, with a bit of luck along the way. I can explain that, if you're interested.

Q. The first question is: what was the role of the committee, what was its objective insofar as you saw it?
A. Yeah. The role as we saw it was to establish a rural medical school west of the Great Dividing Range and hopefully in Wagga, and we had good reason to have it in Wagga because we'd had the rural clinical school here, which was one of the first in Australia. We had been - you know, it had very good academic results. We had a good base of medical specialists, locally resident, who are Australian trained. We had a base hospital, we had a private hospital where they could, you know, also have some exposure. We had the Aboriginal medical service and so on all in one sort of precinct. And, you know, we sort of felt that we're a major regional capital, I mean, we're the largest city, if you like, west of the Great Dividing Range. And so we thought, well, now is the time.

All the evidence was pointing towards, and has now proven, that we're going to get much better results if we have them from day one here rather than halfway through their medical degree, et cetera, and that by having a medical school here with all the associated appointments and so on, you are going to build up the infrastructure base and the knowledge base and the human capital, if you like - I mean, I'm a big one on human capital - that would then continue to foster and mentor the interns and resident medical officers as they approach, you know, to decide what vocational, if any, they will do, and then also then establish vocational training programs that are regionally based/rurally based rather than metro based. So that was the design.

We spoke to both Charles Sturt University, who were very keen to have a medical program, as well as the University of New South Wales, who were obviously already here, and there was a lot of negotiation that went on between them, and discussions and so on, yeah.

Q. Throughout the same period, I think you were the chair of the Riverina regional medical specialist recruitment and retention committee?
A. That's right.

Q. I might call that one the committee going forward --
A. Yes, it's a long name.

Q. -- because it's a big name?

A. Yes.

Q. You were the chair of that from, I think, 2007; is that correct?
A. Correct.

Q. Again, who was represented on that committee, maybe starting just with the general types of people; we don't need all of their names.
A. Yeah, well, originally it was Calvary Hospital, our radiology practice, who were the funders of it, Gerard Carroll, and Joe McGirr at that time was an administrator, senior administrator, in the Greater Southern Area Health Service and so he was on it as an area health service representative. So it was collaborative, private, public, funded by private. We then also employed a full-time manager, so to speak, who was the person that sort of, you know, helped manage the pipeline and do all the sort of support sort of stuff, any potential personal social sort of support stuff for any potential recruits.

Q. We will come back to that. So what did --
A. Yeah. And that grew. Sorry, it then grew. So then we got the PHN involved, the Murrumbidgee Primary Health Network, the two medical universities here, so University of New South Wales and UNDA, because they have a clinical school here now. Wagga City Council we also got involved early. And then once the regional training hubs were established, which are obviously associated with each of the universities, we got their representatives as well, yeah.

Q. So what did you see as the objectives of the committee?
A. Okay, to increase the number and quality of locally resident medical specialists in the city and region.

Q. And how did you go about, as a committee, achieving that?
A. Well, one is just starting the collaboration, which I think was really important, because obviously the public sector have their ways of doing things, private very different, and so to have that --

Q. When pausing there, when you say that, what are the fundamental differences between those two sectors?
A. Well, I mean, the public sector is constrained by its

budgets and so obviously it, you know, cannot put on say a new proceduralist unless there's some sort of funding to fund all those procedures that are going to get performed and as the city grows and medical care increases in complexity and so on, that becomes an issue for them. Because we might find the most fantastic Australian-trained surgeon who is a medical student here who wants to live here, he is - he or she, you know, might be both partners, you know, whoever, he and he, she and she, doesn't matter, want to live here, but there isn't any current position available for them in the public sector, and they want to do some public work. They don't want to be just a private VMO in the private hospital, let's say. There are obviously issues there.

So while on the public side, of course, if you have a quality doctor that wants to come and provide services here and they're willing to be a VMO at, say, Calvary Hospital, which happens to be the private hospital here, to do surgery and see patients in their rooms and so on, of course, we would always welcome that, but they don't need to get approval from, you know, the public sector or - with respect to their budgets and their - all the bureaucratic structures that allow them to appoint someone to a public hospital. Does that make sense?

Q. So again, correct me if I've misunderstood it, but there are some bureaucratic hurdles, for want of a better phrase, that, within the public system, need to be cleared in order to appoint someone to a particular role, which includes making sure there's funding available, making sure that a decision has been made to deliver the service that that particular person can deliver in the location that that person wants to deliver it?
A. (Witness nods).

Q. Once all of them are cleared, assuming they can be, that person can be employed, but that's a process --
A. Mmm.

Q. -- whereas within the private system, say through Calvary or a private provider within the area, those hurdles, there are fewer hurdles?
A. Yeah, there are fewer hurdles. I mean, there's a very similar credentialling process, in the sense obviously you've got to look at the candidate and make sure they are truly who they say they are, they have been trained the way

they say they've been trained and they are actually capable of providing those services in a safe and efficient manner, and to work with colleagues and work in a team, they're exactly the same. But it's, yeah, it's making sure that there is actually that position available and the funding available to provide those services, which is very different in the public sector compared to the private.

Q. So is your point really there in terms of the collaboration, if you managed to find a candidate who is seen to be a good candidate to bring out to work in Wagga, you utilise both systems to work out what the most efficient way of locking them in is?
A. Yes, absolutely, depending on their choices as well. But you often find that these people coming out of a training program are very keen to work in the public sector and often they've never done any private work at all. So they initially sort of start out in the public, and then they, if they open up rooms, they often find that that becomes very busy and so on. But, you know, they work across both sectors, and it's much better that they do. And wherever there is that collaboration, both at that service level but also at the workforce planning level, we've always been more successful.

Q. In terms of the need for the committee, was that driven by what you perceived to be a shortage of specialists within Wagga Wagga?
A. It was. It was first started up as a physician recruitment program. It was so successful that it was just expanded to all medical specialists, but not GPs. We can talk about the GP thing separately. It is a very separate sort of space. Because Wagga being, you know, having the base hospital and so on, a regional centre, there is clearly the infrastructure here to support, you know, fairly - very high-end medical specialist services. Very different if you're talking about GPs further out. And, yeah, so - sorry, I've lost track of --

Q. The question really was: was there a shortage of specialists in Wagga relative to the community's needs?
A. Absolutely, yeah. And there still is in many specialties, yeah.

Q. At least from the perspective that you have, is this a uniquely Wagga Wagga problem or is it --
A. No.

Q. -- wider?
A. It's the same all across Australia and many other parts of the world, yeah.

Q. And what are the real recruitment retention challenges, as you see them, in terms of specialists within particularly a rural or regional setting?
A. The simplest answer is there's not enough rural and regional training because all the evidence shows that if we had enough regional and rural training, then more than 50 per cent of those graduates would choose to live and work rurally and so we wouldn't have the problem, so - yeah.

Q. Can we break that down. When you say not enough rural/regional training, are you referring to training from the day that they start as an undergraduate all the way through to the day that they might commence, hang up their shingle and move into their own rooms?
A. Correct.

Q. And, if so --
A. Yes.

Q. -- does it operate differently at different levels in terms of the availability of training and the difference that it makes to recruitment retention?
A. Yeah, okay.

Q. Maybe take us through the timeline.
A. Sure. I mean, I see it as a pipeline. You want to encourage high school kids to want to do medicine, okay, and that's why we have - now that I'm on the oversight council of the University of New South Wales Riverina medical school, we've supported Professor Tara Mackenzie and her staff in the establishment of these programs where they have contacted all the high schools in the region and they encourage kids who have an interest in science and who might have the academic ability to do medicine to think about medicine as a career, engage with them and so on.

So you want to - and you want that to be as broad as possible because, you know, hopefully there will be one day a kid that comes from Lake Cargelligo who wants to become a doctor and goes back to Lake Cargelligo to live and work. And at the same time there's also a separate Aboriginal

program that goes along with that. So that's the first step of the pipeline.

The next step is the medical school, and we now finally have a medical school here in its third year. It only has 25 students entering each year, and so that won't be enough, you know, for the need that's out there, but it's a start.

After that, you then have the internship and the RMO time where you want your best and brightest and those who are more likely to stay rural to stay, and that's where there's been a lot of work done at Wagga Base, and so on, I mention Joe Suttie by name, but others, who have helped foster and mentor in those junior doctors the desire to stay in Wagga, such that Wagga became the most popular hospital in the whole of New South Wales in terms of its choice, of, you know, where people wanted to come.

Q. So that mentoring and encouragement to stay, presumably wasn't confined to those students who happened to have been through --
A. No, no.

Q. -- clinical placements out here during their study?
A. Yeah, anyone who became an intern or RMO at Wagga Base got that same encouragement and then sort of, "Okay, where do you want to go in terms of your longer term career?" "Okay, well, let's work out how we can get you into that vocational training program."

But then you've got the vocational training program, most of which are metro based, very few are truly regionally based. But the Commonwealth gets this, which is why it started up the rural training hubs, the regional training hubs and all those sorts of things, as you know the - what's it called - the rural health multidisciplinary training program. It realises that the more you train rurally, the more will choose rurally. But how do you - you then have to start up programs that are truly regionally rurally based, which requires infrastructure, administration, you know, some level of commitment. People have to pass all the exams and so on. So you've got to provide all those other support things and you've got to have enough of them there so - more than one, because usually, if they're - you know, they like to be in a study group or all those sorts of things. So then there's that.

THE COMMISSIONER: Q. Are we talking now training for a specialty?
A. Correct. And that might be - I mean, we can talk about GP training as well, but let's say the non-GP specialty vocational training programs.

And then, beyond that, then you need to help settle them into a community, and while they may have spent - hopefully, in the future, more and more of these candidates will have spent more and more time in the community so they're already settled or half settled, but when they come out of that training program, as I say, they've spent virtually all their time in the public sector, they don't know how to start up a private practice, they've got - often have partners, kids. You know, they're thinking about, "Where do I buy a house", if they don't already have one, "Where might my kids go to school", all those sorts of things.

So the manager's role in the medical specialist committee, her role - it's currently a "she" - is to engage with those people and try to work out, "Well, where would you like to live if you don't have a house? Where would you want your kids to go to school", help settle them. Like, "There are all these practices here that have spare rooms while you get settled that you can work in those rooms until you decide to open your own rooms or do whatever."

And then, at the same time, you know, their partner might have a need for - you know, they might - often, most of the time now, they've got a job, but it may not be in medicine, it might be in, well, engineering or goodness knows what, you know, human resources, who knows, a trade; they're a small business person. Okay, how can we facilitate their sort of integration into the community so they can make a living and connect them socially, and so on, so that they're much more likely to stay and more - more likely to come and more likely to stay.

MR MUSTON: Q. So as we walk through that pipeline, you're targeting the students, the high school students and encouraging them to think about studying medicine?
A. Yes.

Q. You've got an increasing cohort who are being trained

locally as undergraduates, which involves a significant degree of clinical exposure, locally or within rural and regional areas?
A. (Witness nods).

Q. You have, hopefully, those students or a cohort of them, plus a number of others from Sydney who are drawn to the popular training spots in Wagga Base Hospital. What about the vocational training? Is that something where you feel that the pipeline runs freely or do you think there's a blockage in the pipe at that point?
A. Oh, well, we definitely need more regional/rurally based training. That is something that, you know, had already been started in general practice and - but, you know, the model needed to be improved in many ways, which has happened with the single employer model and so on. And now that the two colleges have, you know, collaborated and back in that training space, I think that's a great start.

But when we're talking about non-GP medical specialists, clearly, there's not - there's very few truly regionally based training networks, because most of them are now training networks, not just one hospital anymore, and so we need to expand that. We need to increase and expand it, yeah.

Q. Is that for similar reasons to those that were given to you at the time that you initially tried to get the training spot up all those years ago?
A. No. I think --

Q. What are the reasons, as you see it, for the absence of rural vocational training spots?
A. There is still a cultural element within some of the colleges, or many of them, you know, depending on who is president at the time and who is on the council or board at the time and all those different sorts of things.

Q. I'm just going to ask you to pause there. To the extent that it is a cultural or mindset element, how is that cultural mindset manifesting itself as an absence of a training spot in, say, Wagga?
A. Well, because you need the colleges to accredit your training programs, so they all have accreditation committees and so on, and so unless there's a primary policy objective of the college to increase such regional/rural based training programs, you end up running

into all the other sorts of barriers within the college of, you know, the accreditation committee, who's on that, you know, do they understand what you are trying to achieve with regional and rurally based training, very different to coming and accrediting a major teaching hospital sort of service site, with, you know, all its stuff, all its support stuff, versus coming out here and sort of, you know, saying, "Oh, gee, you don't have any staff specialists. It's all VMO staff. Yeah, they'll be spending time in the private practice, oh, lots of time in the private practice", okay, and it's just a - you know, it takes them a while to get around that, and some don't, if you understand that, as an example of a cultural issue.

Q. Are there any in particular that you think are struggling more than others to get over these cultural barriers?
A. I think that the college of surgeons and the college of physicians are way ahead of most of the others, but that includes paediatrics in that, anaesthetics in surgery, okay. So that covers a fairly broad range.

I think as a radiologist, unfortunately the college of radiologists is behind the ball, the college of pathologists is behind the ball, and the college of obstetricians and gynaecologists is behind the ball. I would have said five years ago the college of psychiatrists was behind the ball, but they've really swung in behind it and now have a really good - you know, certainly in this city have some really good rurally based regionally based training.

Q. Can I come back to the GP issue that you raised a little bit earlier. I understand your committee is focused on recruiting specialists, non-GP specialists.
A. (Witness nods).

Q. From your perspective, do you think there's any aspect of the system which is disincentivising a move into general practice?
A. Yeah, well, there must be because, you know, 30 years ago, 70 per cent of medical graduates chose general practice, or 40 years ago, and now the Australian data is less than 14 per cent are choosing general practice.

Q. Why do you think that might be? Is there some systemic reason for that?

A. Yeah, there are systemic reasons, the fact that too much of the training is based in metropolitan teaching hospitals and, you know, the medical school culture, you know, the aspiration, "If you want to go anywhere, you've got to be an RMO at a hospital that has its own TV show", and all that sort of stuff. And most of the training programs are sort of like based in those hospitals and run by people who work in those hospitals, and so that's a huge cultural element and - can you ask the question again, sorry, because there was a second part --

THE COMMISSIONER: Q. Why are so many medical students choosing specialisation, non-GP specialisation instead of being GPs?
A. So I certainly think there's a metropolitan bias in that system.

Q. I think you were saying, look, they go into these big teaching hospitals and I think the implication was that the teachers are encouraging them to go into specialisation?
A. Oh, yeah, absolutely, and to be a GP is second rate, and particularly a country GP well, you know. But the other thing is, too, that general practice, if you look at the income --

Q. Sorry to interrupt you, is there an issue with the medical schools themselves not getting the message out, if this is the right message, that general practice is the backbone of the medical health system?
A. Without a doubt. Without a doubt. I mean, the University of New South Wales, the only - that I'm involved with, doesn't have a department of general practice.

Q. Sorry, I interrupted.
A. Then the other thing I think, too, is you look at the income and the job you're going to be doing. If you're going to be a country GP, you're not going to make a lot of money. There will be guys working on the roads who probably will have a better income than you, and yet you're going to have all this responsibility, you've got to run your own business, you're going to be woken up in the middle of the night to go into the local hospital to deal with someone who's having a life-threatening issue, and it's hard work, it's very challenging. You don't have radiology to call on or pathology; you don't have a resident, a registrar, a local consultant you can call. It's very challenging work and it's not remunerated

particularly well, and nothing like some of the other - you know, not all the medical specialists, but potentially, say, the proceduralists.

And so I guess some - you know, and particularly if they're then faced with a culture that tells them well, to become a GP is really - you know, like, "Do you really want to become a GP?" It makes it hard, which is why we need so much - you know, why we need rural medical schools and so on, to start from day one showing them how important general practice is and how fantastic a career it is.

But at the same time, the State of New South Wales needs to change its focus and, you know, stop being so metro-centric itself with respect to the health department and go, "Oh, okay, righto, we do have this problem. The reason why there are these poorer health care outcomes is, you know, the workforce shortage is a major part of that. Okay, let's really get behind the means and the sort of opportunities that are there to increase the amount of rural training and to increase the profile of rural generalists and rural GPs so that more will choose it." Yes.

MR MUSTON: Q. I think I have diverted you a little bit. I was asking you about the challenges in terms of recruitment and retention amongst the specialist cohort. Not enough training is the first one you gave us, and we've explored that a little bit. Are there others?
A. Yeah, I mean, I say that because that's what the evidence would show. That's the main one. But then it's a question of having enough people who are regionally/rurally based to provide that training.

When there's a workforce shortage, it means that those people who are in that position, one, are service challenged, you know, they're already sort of time poor, and there aren't the same sort of legacy sort of infrastructure around to support it all in terms of postgraduate training departments and paid positions and all those other sorts of things. And so you have to find those people who are willing to commit to providing the time, and most of the - like all the teaching I've ever done, it's always been volunteered; you didn't get paid a cracker for it.

But someone has to pay at some point, and particularly

when there is such a workforce shortage. And so my message to the State of New South Wales is that you really have to look at - we've got to value those doctors who want to work in the system and who want to train while they're providing services, and - yeah.

Q. That's an extension of the not enough training piece?
A. Yes.

Q. Any other challenges that you see as being particularly acute in the context of recruitment and retention of specialists to regional areas like Wagga Wagga?
A. No. I think they're really the - that's what it boils down to, I think, yes.

Q. So in terms of what your committee is doing to try and meet some of these challenges, you told us a while ago that you've employed a manager who seems to be a concierge for the people?
A. Correct.

Q. How do you identify the people who should be given the concierge service?
A. That's a really good question. We find the best candidates are those who we've identified from an early stage, if they've been at medical school or junior hospital stage or while they're in their training, you know, they seem to be good doctors who want to live rurally and so as soon as that sort of - you get the two of those together, you know, the lights go on and we start really sort of engaging with them.

Q. What does that engagement look like at that early stage?
A. There are two parts. There is the professional peer part, because it's only the peer doctor in that vocation who can, you know, if they're a physician, to decide is this candidate, and let's say they become a physician trainee, going to be a good physician? If they're a surgical trainee, are they going to be a good surgeon and so on.

So there's that sort of part where it's the locally resident specialist who, you know, you hope that - there are some out there who are very good at it, at identifying the potentials, and then engaging with them and mentoring

them, staying in touch, and, you know, being available for them to answer questions and to sort of build that culture of this is where you should come and work. And at the same time, we then have that, as you say, concierge person there who engages with them on the other side and sort of finds out, okay, are you in a relationship, do you have a family, what are the things in life that you want out of your life, beyond just work? And then makes sure that we can cover off on those, identify them and then work out how we're going to solve any problem issues.

Q. So what might be some examples of that, the wider life concierge service?
A. Well, kids and schools is a huge one. Partners and their career aspirations is the next - they're the two biggest things, okay? 51 per cent of it, I find, is the partner, and kids are a huge thing. And schooling, kids and schooling. So that family sort of stuff, and most people are - very rarely do we not have someone - off the top of my head I can't think of anyone who hasn't been in a family situation.

Q. Is that part of the challenge presented by the fact that a lot of this vocational training is happening in a metro setting and at a stage in people's lives when they are meeting people, marrying people and --
A. Exactly.

Q. -- having little people?
A. Exactly. Exactly. That's what happens. They're choosing life partners and having families, and if they're doing so in a metro setting, if that life partner has a job at some big city firm as an HR specialist or whatever, and they've got maybe family support there for the young kids to help with daycare and all - you know, school drop offs and blah, blah, blah, while the two people work, and both of them might be medical specialists, who knows, then it's going to be very hard to get them out, yeah.

Q. Is your view that if the training could be adjusted in a way that meant that golden period when they are meeting people, buying houses and starting families was happening in a regional setting, that would greatly increase the prospect of at least a number of candidates staying?
A. Mmm, and all the evidence shows that that's the case.

THE COMMISSIONER: Q. When you say "all the evidence",

you're referring to the many papers you have provided us?
A. Yes, that's right. Yeah, that's right. And it's also been our experience, but - yeah.

Q. Lived experience?
A. Yeah, it's a lived experience as well.

MR MUSTON: Q. In terms of that experience, to what extent have you had a good strike rate in terms of keeping those specialists that you've identified at that early stage?
A. Yes, sorry, come back to that, the original question you asked, how do we identify the candidates? Well, those are the best ones, those ones that we - we have a really good strike rate if we identify them early and mentor them and support them through all that. We don't have such a good strike rate - it's - you know, it's almost, let's say - let's say we need a radiologist in the city, which we do. You advertise. You don't get any Australians applying, for 10 years, but you're inundated with overseas trained radiologists who would love to come and work in Australia as a radiologist.

And then - and so trying to entice - and what we do is - because you won't find enough of - well, we, at the moment, haven't been able to find enough in that sort of pipeline because the pipeline hasn't been established long enough or isn't big enough; it will increase with the medical school here and so on. So for instance, you know, we would pay to have a booth at the annual scientific meeting or the annual society meeting of neurologists or radiologists or obstetricians, gynaecologists, so we go there with a radiologist or, you know, depending on what the specialty is, you know, there might be a senior administrator from the hospital, there is this manager, and we have a barista, and everyone that walks past, you try and engage them and, you know, "Why don't you come to Wagga? Great lifestyle", whatever, or, "No, no, I'm not interested", "Do you have a friend, a colleague?" You know, like - and out of that, you know out of those contacts for every 100 people you might meet, there's less than 5 per cent where you might get something useful that you can follow down the path, and in the course of five years, one half of that 5 per cent might actually, you know, be interested in coming here. So very low strike rate.

Q. What about overseas trained specialists? Do you see your committees having a role in trying to attract suitably qualified overseas specialists to work in Wagga?
A. Absolutely. When there's no other choice, yeah. But you have to be very careful if they're going to be a proceduralist. If you're going to have someone operating you on you, you really want to be certain that if you're attracting this person here and then potentially offering them positions and so on, that they are well trained and that they're safe practitioners.

It's a very different situation to when they've - either you've known them through their training, which is obviously the ideal way to make that assessment, or they're Australian trained, where there is always someone, usually, within their referee cohort or someone that you know from their CV that you know, you've worked with, that they've worked with, that you can sort of make those assessments.

But when they've trained overseas it's very difficult. So there's got to be, you know, a sort of culling process, if you like, to try and make sure that any potential candidate is truly a quality candidate, and particularly a safe one, if they are going to be doing particularly procedural work. Imagine if they're going to be a paediatric surgeon or something, you know?

And the thing is that you get inundated with these - either they directly contact you or they come through locum agencies - not locum agencies, they come through agents, recruitment agents and agencies that come with their own sort of cost structure, and so, you know, for the amount of people that contact us, there's very few that we see of that quality. Then to get them here is a process in itself, because there's a whole lot of visa things, there's college assessments and so on. You've got to employ a visa specialist, you've got to work out what the - every college is a little bit different how they assess them and -- -

Q. Who deals with all of that procedure if you're dealing with overseas recruitment?
A. Well, yeah, our manager oversees that, with the assistance of the specialist who is local. But then we use, as I say, these - we pay specialists. Like, there's a particular woman, Dot, who is fantastic at this. She knows all the colleges, you know, what the process will be for this particular medical oncologist or whatever, to

navigate through, you know, immigration, college and what - which one you go through first, because that's going to be the first limiting step, then what the next one is, what the next one is, what the next one is, yeah.

Q. Is there anything that you think NSW Health or the LHD might be able to do differently to improve that process?
A. Well, I think they do pretty well. I mean, we - they've supported us in that, and --

Q. Can I ask you to pause there for one minute. Is the famous Dot employed by NSW Health or the LHD?
A. They have paid some of her costs in these settings, when it's recognised that this particular specialist is, you know, crucial to the provision of safe and adequate services in a base hospital, and so they have contributed to some of that, yes, they have.

There are also up-front costs. Like, the colleges might demand $5,000 up-front to assess that candidate. Then there's the Department of Foreign Affairs and Trade, or whatever, immigration charge, you know, like a $7,000 fee and all these other sorts of things. So the LHD have been helpful in that regard. And so - but also it's making sure that their own HR department is linked in with all of this. But over the years we've managed to create a system whereby we can be confident that they are linked in with that so that - because the last - it has happened that we've identified people, either from overseas or Australian trained, who are ready to move here, but then the HR department of the LHD drops the ball and doesn't offer a position for six months and then they go off somewhere else.

But we've got the - you know, that was in the past. But now we've got to the position where the HR department, whatever you want to call it, okay, the medical - or, you know, whatever, I don't know, whatever title it gets given these days - are linked in with our meetings and they're aware of this candidate, who we've been talking about for two years and, okay, this is where they're at, and Dot is doing this, okay, so we'll be ready to do the next thing when that's the next step that needs to be taken. Does that make sense?

Q. Are there any particular resources that you think the state could make available which would make the work of

your committee easier or more effective?
A. I mean, it is something that has grown locally here and the LHD have been reasonably supportive over time, but whether that would be replicated across all LHDs, of course, is - who knows.

Q. In terms of "who knows", what is your view about whether or not it's something which is capable of being replicated in other rural or regional areas?
A. It's hard to know, isn't it? I think every LHD might be a little bit different in that regard, depending. I mean, we have the support of the chief executive here and have had, and that's - and therefore, it's been achieved. It's actually, the chief executive who signs off on the heads of agreement about the collaboration, and so when we're having trouble, say, for instance, getting a director of medical services to attend meetings or, you know, to provide information, well then that - we get the support of the chief executive and that changes.

So it needs that level of - it does need some top-down sort of, you know, stuff, and I think that - but certainly the - I think all LHDs need to understand that - and particularly out here, like, it's different in the city where you have 100 people applying for one position, when there's nobody applying for a position but then, next year you might find someone who's Australian trained who's eminently suitable for that position, you've got to be in a position to pounce and to cover off on it.

And so making sure that there is that understanding and support within the bureaucracy to tick off on that is critical, and whether that happens both at the health department level as well as in the LHDs, you know, I think that could be problematical in some LHDs and also from the health department itself, but I think that's something that, you know, should be looked at to make sure there is going to be that support, because it's a very different way of signing people on, if you like. Does that make sense.

MR MUSTON: I've got no further questions for this witness. Thank you, Dr Stephenson.

THE COMMISSIONER: Mr Chiu?

MR CHIU: No questions, Commissioner.

THE COMMISSIONER: Thank you very much for your time. We're very grateful. You are excused.

<THE WITNESS WITHDREW

THE COMMISSIONER: The witnesses, both of them can fit there, can they?

MR GLOVER: We just need a moment to configure the space.

I call Narelle Mills and Melissa Neal.

<NARELLE MILLS affirmed: **[2.57pm]**

<MELISSA NEAL, affirmed: **[2.57pm]**

THE COMMISSIONER: Mr Glover will ask you some questions.

<EXAMINATION BY MR GLOVER:

MR GLOVER: Ms Mills, can I start with you. Can you state your full name for the record, please?

MS MILLS: Narelle Mills.

MR GLOVER: You are currently the interim CEO of the Murrumbidgee Primary Health Network; is that correct?

MS MILLS: Yes, that's correct.

MR GLOVER: And, Ms Neal, your full name for the record, please.

MS NEAL: Melissa Neal.

MR GLOVER: You were the immediate past CEO of the PHN; is that right?

MS NEAL: That's correct.

MR GLOVER: Do you currently have a role with the PHN going forward?

MS NEAL: Yes, I do, a senior adviser.

MR GLOVER: I might start with some background information about the PHN, and I'll start with you, Ms Mills. Could

you just describe the role and function of the PHN in the Murrumbidgee Local Health District?

MS MILLS: Sure. So primary health networks are a Commonwealth funded program. There's 31 PHNs nationally. In the Murrumbidgee region, the PHN program is delivered by Firsthealth. We deliver the PHN program across the same locational boundaries as the Murrumbidgee Local Health District 250, something, square kilometres, you know, 508 communities, and we essentially serve or deliver on three different areas. One is around that coordination of local services and with the aim of improving coordination of care.

We also look at what the needs are of our communities and commission services to meet those needs. And then, thirdly, we have a strong focus on working with our primary care providers and supporting the development of capacity, capability within primary care.

MR GLOVER: I will come back to a few of those elements in a moment. In that answer, you said that the PHN was delivered by Firsthealth; did I hear you correctly?

MS MILLS: Firsthealth is the name of the company and we deliver the PHN program.

MR GLOVER: That's a not for profit organisation?

MS MILLS: That's correct.

MR GLOVER: Which is engaged by the Commonwealth to deliver the PHN program within the district; is that right?

MS MILLS: Yes, that's correct.

MR GLOVER: You said it was federally funded; by that do you mean the funding comes from the Commonwealth Government?

MS MILLS: Yes, it is funded from the Commonwealth through their grant program. So the majority of funding that we receive as Firsthealth is through the Commonwealth. However, we do receive funding elsewhere, such as through NSW Health and other grants.

MR GLOVER: The funding that comes from other sources, is

that tied to particular initiatives?

MS MILLS: Yes, usually that's the way that works.

MR GLOVER: In that answer, you mentioned that there's an assessment of the needs of the community that's done by the PHN. How is that done?

MS MILLS: So there's various strategies that we use to undertake our needs assessment. One of those is utilising our gold standard data sources, so through the Australian Institute of Health and Welfare, ABS data, hospital data. A lot of that data does go down to a PHN level so we're able to drill down into what is happening for our region.

In addition to using that data, we also undertake. I guess, that community engagement to hear what's actually happening on the ground, and again we do that through a number of different strategies.

We have a survey that we continually run where we might aim to engage priority populations to complete that survey, which is letting us know about what their - what the health issues are for the region.

We also undertake what we call "Conversations on the Couch." That's a program where, over a three-year period, we'll visit every community across the region with a population of 1,000 and above. We will have a couple of staff who will set up in a local cafe or a local spot to have those conversations with locals to try and, I guess, pull out what are the needs that are occurring in communities that you're not going to pull out of the data, the big datasets.

So we use that to help inform what some emerging themes might be across our regions. From that we also have "Yarns on the Couch", which is where we aim to engage our Indigenous populations and again have a conversation around what they're seeing in their communities.

We utilise all of that data along with the data sources to pull together a needs assessment which we submit. We do what we call a full refresh of that needs assessment every three years, and that is submitted to the department, and then every 12 months, we do an update that also goes to the department.

MR GLOVER: The department there being the Commonwealth department?

MS MILLS: Commonwealth Department of Health and Aged Care.

MR GLOVER: How is that needs assessment once completed, or throughout its evolution, used in the work of the PHN?

MS MILLS: So we are required to publish the data, the needs assessment, so it goes up on our website. We develop local profiles for each of our communities, and so again, that's all made available through our website. And the reason we do that is to make sure, or to enable all of our communities, and whether that be the LHD, councils, any other groups or organisations across our region, to understand what the local health needs are, so it's available for others to utilise.

I guess the second part of that then is that we utilise that data to prioritise where our services might need to go, that we commission.

Every year we are required to submit to the Commonwealth Department of Health and Aged Care what we call our activity work plans. These are aligned to our funding schedules and so as part of that funding or submitting the work that we're going to do as a PHN, it has to align to our needs assessment.

MR GLOVER: When you say "our services", in that answer, what do you mean?

MS MILLS: So as a primary health network, as I mentioned, one of the areas that we deliver on is commissioning of services. So that's where we will identify what the needs are in our communities. We have specific funding through the Commonwealth to be able to commission a service.

So, for example, probably a significant proportion of our funding through from the Commonwealth is focused on mental health services, so we will commission private providers or, you know, it could be the local health district as well, we will commission a provider to deliver on a targeted mental health service.

MR GLOVER: This is the delivery of a service that is not otherwise currently available in the community?

MS MILLS: Yes, yes. So as part of, I guess, that needs assessment and developing those services and that commissioning approach. So when we talk about "commissioning", we talk about understanding the needs, but we also talk about understanding what the market is and who's in the market already delivering that service or where the gaps are and/or potentially who could deliver on that service.

MR GLOVER: Ms Neal, did you have anything to add to that example?

MS NEAL: I think that summarises the process that we undertake quite thoroughly.

MR GLOVER: Are there any other examples of commissioning of services that you can draw to mind?

MS NEAL: Yes, there are a range, so obviously mental health services being one. But, yes, one of the limitations of the primary health network funding, potentially not unlike the state, is that our flexible funding pool is quite limited. So that is funding that the PHN has full discretion over in terms of how it directs funding to meet needs. Whereas a number of our other --

THE COMMISSIONER: Is your budget annual?

MS NEAL: It is an annual budget. The aim is to have a three-year funding cycle, but it is managed on an annual basis.

THE COMMISSIONER: When you say "The aim is", that's the desire?

MS NEAL: That's the Commonwealth Department of Health's intent. However, our funding renewals don't always - aren't always received in --

THE COMMISSIONER: Currently you're on an annual budget though?

MS NEAL: Yes, annual budget and planning process.

THE COMMISSIONER: You might have some programs that are funded for more than one year?

MS NEAL: Yeah, out to - our current funding, the most extended program would be out to 2026.

THE COMMISSIONER: Okay, so they're like - does that mean three years or --

MS NEAL: Three; three years is the intent.

THE COMMISSIONER: And what is the Murumbidgee PHN's budget, annual budget?

MS NEAL: The annual budget would be just over $40 million, and that flexible funding pool probably represents about 4 to 5 per cent of our total funding.

THE COMMISSIONER: So that means what, 35 million is committed to specific programs and then there's this $5 million or - sorry, what percentage?

MS NEAL: Five per cent.

THE COMMISSIONER: Five per cent. So then there's that small amount, it's only about $2 million of the 40, is it?

MS NEAL: Yes, which is directed to targeting the local needs outside those particular program areas of funding. So as further examples, they include palliative care, mental health, drug and alcohol, after-hours funding, as examples of those particular funding streams in addition to mental health, psychosocial programs.

MR GLOVER: Those are examples of programs from the flexible funding?

MS NEAL: No. They're funding streams from the Commonwealth and then we have the flexible funding pool.

MR GLOVER: What was the particular challenge that you were describing in relation to the limited flexible funding pool?

MS NEAL: So, you know, we've mentioned the needs of the region. We have some of the highest rates of potentially preventable hospitalisation for chronic disease and some of

the worst health outcomes in the nation for chronic disease, and risk factors. So the challenge with such great need across a very large geographic footprint is how to meet those needs with such a limited funding pool.

MR GLOVER: And as part of that endeavour to meet those needs, the PHN engages fairly closely with the local health district; is that right?

MS NEAL: Absolutely.

MR GLOVER: Is one of the measures that the PHN is involved in to address at least some of those concerns, the collaborative commissioning initiative?

MS NEAL: It is, yes.

MS MILLS: Yes.

MR GLOVER: Have you both had some involvement in that in your time at the PHN?

MS MILLS: Yes, I have had involvement in that in my previous role as executive, integration and partnerships.

MR GLOVER: And Ms Neal, in your role as CEO at the time. Did you have some involvement in that program as well?

MS NEAL: Yes, so overseeing the implementation of the program and as a role also as a co-chair of the patient-centred co-commissioning group.

MR GLOVER: We will come back to that group in a moment. We've heard some evidence this morning about the collaborative commissioning initiative, but I'm interested to hear from the PHN's perspective its benefits and limitations.

Starting with the benefits, Ms Mills, what benefits does the PHN see in the collaborative commissioning initiative as it's being rolled out in this district?

MS MILLS: I think that there are significant benefits around that joined-up health service. So we have the state and Commonwealth funding, which can drive, I guess, that division for the patient in terms of the patient journey. So when they're travelling in and out of a primary care

system into an acute care system, there's - the risks there is for the patient to fall through the gaps and, you know, the handover of care between those two systems is quite - can be quite significant and have significant outcomes for patients.

MR GLOVER: Do you see that being driven in part by the funding structures that currently exist in those two streams?

MS MILLS: Yeah. So collaborative commissioning, because it is jointly governed and we - both the PHN and the LHD - have, I guess, joint accountability for the funding, it ensures that we're working on a care pathway that is joined up, which will have better outcomes for patients. So --

MR GLOVER: What responsibility does the PHN have for the funding in relation to that program?

MS MILLS: So we're involved in all of the decision-making around how that funding is allocated across the program. So there is joint decision-making between the PHN and the LHD on how that funding is allocated and whether that be for services that are being delivered purely by the LHD or for activity that might be being delivered in primary care, there is, I guess, joint decision-making in that.

So through our PCCG, when we're deciding on how we might allocate the funding or services that we might progress with, there's always - that decision-making sits with the two - the CE and the CEO - on how that progresses.

MR GLOVER: I diverted us into funding while you were talking about benefits. What are the benefits from the PHN's perspective of the initiative?

MS MILLS: I think it helps to alleviate service duplication but also helps to connect primary care with the acute care system.

MR GLOVER: Why is that important?

MS MILLS: I guess for that continuity of care for the patient, and so if we've got general practice engaged, and GPs know their patients really well, they understand what's happening for their patients, and so what can happen is once the patient, you know, goes to ED or goes to - for

admission to hospital, they can lose understanding of what's happened to their patient until they come back out into the community again, so part of collaborative commissioning is trying to work out how do we ensure that primary care is - remains part of that care pathway.

MR GLOVER: What about for those patients who may not have access to or have not accessed, for a variety of reasons, primary care before they first present to ED? Are there benefits in the program for that patient cohort?

MS MILLS: Yeah, I guess part of the, you know, working closely with the LHD is then - and as part of collaborative commissioning, is looking at how we can particularly identify people who are at risk and get them linked back in to a GP.

MR GLOVER: Ms Neal, do you have anything to add to that?

MS NEAL: I think one of the other benefits is it optimises care for patients in the community and what we've been able to do is really focus on gaps in the pathway. So in particular, looking at early intervention and early diagnosis, which have been in the past significant gaps in the region, with the view that, you know, by optimising care for patients early in their journey, we're avoiding acute presentations, and potentially lengthy hospital stays, you know, down the track, but also avoiding those acute presentations to ED when potentially an individual could have been cared for in the community.

MS MILLS: I was just going to add to that, I think - sorry.

MR GLOVER: Yes please.

MS MILLS: I think the heart failure outreach clinic has been a really good example of where we've been able to, as part of collaborative commissioning, bring that specialist care and that diagnostic care into primary care. And apart from the benefit for the patient in being able to access those services in their local community, it also enables that upskilling for general practice as well.

MR GLOVER: That's an example where services are delivered in parts of the district that may not have otherwise had access to them; is that right?

MS MILLS: Yes.

MR GLOVER: Has that, to your observation, led to better patient outcomes?

MS MILLS: At the moment, what we're seeing in the data, definitely, particularly with the heart failure outreach clinic, being able to diagnose patients in the community rather than waiting for them to end up at ED.

MR GLOVER: The collaborative commissioning initiative in this district is at present aimed at COPD and CHF; correct?

MS MILLS: Yes.

MR GLOVER: Do you see there being benefits in it being expanded into other areas?

MS MILLS: Absolutely.

MR GLOVER: Are there any particular that come to mind as being amenable to this type of approach?

MS MILLS: I think for people living with chronic disease, they often don't just have one chronic disease, so, you know, for example people with diabetes as well. So a lot of the program is around making sure that people are being managed appropriately in primary care, supporting them on their care journey. If they do need to - if they do have an exacerbation and they do attend hospital, ensuring that they're supported when they come back out, they're linked in with their GP, and I think - and that there's appropriate programs in place to support people once they're back in the community, such as through rehab programs.

I think you can apply that to a number of chronic diseases and diabetes would be one of them in our region. Again, we have significantly high rates of hospitalisation for people with diabetes and the statewide initiative for diabetes is another area that we've just commenced working on with the LHD under our PCCG to start to look at how we can streamline some of those pathways and look at where the gaps are.

MR GLOVER: I will explore that with you in a moment, but

we've heard a little bit in evidence about the challenges of the fragmented nature of health care, which you've referred to earlier.

MS MILLS: Mmm.

MR GLOVER: Some of the benefits you were describing in that last answer go some way to addressing that fragmentation; would that be fair?

MS MILLS: Yes, I think.

MR GLOVER: Ms Neal, did you have anything to add in that regard?

MS NEAL: Yes. I think what collaborative commissioning as an example has allowed us to do is take a funding mechanism that has been much more flexible to address local need, and through the seed funding provided, the space to look at that pathway end-to-end and design local initiatives to meet that. So, you know, in terms of a model and joint governance, around how we realign elements of the system to respond to local need but then also use that funding to enhance what we have, I think it's a good example.

MR GLOVER: And is it fair to say that it works in your view because there is the crossover between the primary and acute care setting pulling in the same direction in relation to that patient cohort?

MS NEAL: Yes. And it's underpinned by - clearly we have joint boundaries. Those two conditions represent the highest potentially preventable hospitalisation rates in the region.

MR GLOVER: Ms Mills, you were referring a moment ago to some expansion into the diabetes initiative through the - under the umbrella, whether so called or at least in the framework, of the collaborative commissioning structures. Can you just describe that for us.

MS MILLS: Yes, so the statewide diabetes initiative is coming out of or is one of the directions of the state level around the agreement between NSW Health and New South Wales PHNs where we've got a joint agreement together to work together on joint governance, you know, planning, data

sharing. One of the initiatives there that's driving that is the statewide diabetes.

Again, it's looking at consistent care pathways across the region for people with diabetes, ensuring that there's a joint governance at the local level, you know, between the PHN and the LHD, to work together on, one, identifying what the issues are, you know, why do we have such high rates of hospitalisations or hospital presentations for people with diabetes; and then looking at what are the - some of the initiatives we can put in place?

I guess, you know, for the statewide diabetes initiative, it differs to collaborative commissioning for COPD and CHF in that we've got a significant amount of seed funding sitting with the collaborative commissioning. For the statewide diabetes initiative we don't have that funding. So that's where we, as a PHN and as the LHD, need to look at what our existing resources are, what our existing services are and how we can align those or make improvements to those without funding, which is a bit of a barrier.

MR GLOVER: Can I go back a step. So this is an initiative that's come out of New South Wales ministry and the New South Wales PHNs coming together.

MS MILLS: Yes.

MR GLOVER: And it's being delivered at the local level by, in this case, the Murrumbidgee Local Health District and your PHN?

MS MILLS: Yes.

MR GLOVER: But do I understand your evidence to be that no additional funding has been provided to implement that initiative?

MS MILLS: That's correct.

MR GLOVER: So how is it being rolled out within the funding envelope that you have?

MS MILLS: So we've commenced working with the LHD on looking at what the needs are. So, for example, we will - or we have utilised our chief data officer, who will pull

together the data that we have available to at least identify what - where the needs are. The LHD have contributed some funding and resourcing to a project person to help try to pull together the current state of play for us to work out what the next steps will be.

MR GLOVER: In some earlier evidence I asked you about the assessment of the health needs of the population and you helpfully described how that is done. Does the PHN engage with the LHD as part of that process?

MS MILLS: We engage with local health advisory committees, they're part of, I guess, our - when we go out, for example, and do "Conversations on the Couch", we'll engage with the local health advisory committee to help support that and help, you know, to identify people who could come along and contribute their thoughts and their - you know, their concerns to that approach. And in terms of accessing data, I think, you know, we would work with the LHD around any other data sources that could be utilised to help inform that needs assessment.

MR GLOVER: From that, do I take it there's no structured engagement with the LHD to assess the needs of the population within the district in circumstances where your borders are identical?

MS MILLS: I'll defer to you on that one.

MS NEAL: So we pull together the LGA profiles, and those profiles are used at times between the services, but that is PHN led. And through the, I guess, operation of our relationship and how we work together, there is absolutely that flow of relevant and appropriate information that can be provided to inform that.

What we are looking at through the work of the health and knowledge precinct is an approach to take a more formalised approach to joint regional planning, including that understanding of needs across the region and how we align and leverage those - the datasets but the wealth of information across not only the health services but potential other contributors, to inform that process. We've just commenced that and we are looking to have that work completed or a framework to help facilitate that work, by around October/November.

MR GLOVER: So will that framework look to establish a more formalised approach between the PHN and the LHD to the assessment of the needs, the health needs of the population within their boundaries?

MS NEAL: Yeah, and in that broader regional planning approach, that was something that has been identified at a statewide level through the PHN/LHD statewide committee, through - we have a joint statement of commitment and out of that joint planning was identified as an area where PHNs and LHDs could strengthen approaches.

MR GLOVER: In your view, are there benefits to that more formalised approach between the PHN and the LHD in assessing the needs of their community?

MS NEAL: Yeah, absolutely. I think there's a few benefits, the first one being improved or enhanced utilisation of data and information that is available on the health of our communities. At any given time there will be a range of different datasets with different point in time information about the health needs of a community. So I think, firstly, the opportunity to enhance our visibility of all that data and information that's available is really important.

I think, secondly, it means that there is a joint understanding of what those needs are, and then that contributes to more targeted approaches in terms of meeting the needs of those communities, and as I said, there is certainly - at the moment we know those profiles, for example, are used in annual local health advisory committee planning sessions which are undertaken at the beginning often of each year with both LHD and PHN representatives, I think a more formalised approach would strengthen that.

MR GLOVER: And would that enable both the PHN and LHD to identify particular gaps in services across the region?

MS NEAL: So I think there are probably two parts to that. The health needs assessment, firstly, looking at prevalence of conditions; and then the second component is looking at service access and, you know, I think that's the potentially more complex bit. So if we think about, as an example, collaborative commissioning and the work that we've done there, certainly we identified the need in terms of, you know, health prevalence and issues, but then

there's a whole - another piece of work along that care pathway to understand what services are currently available in the region, what are the gaps, and then how do we best meet those gaps. That can often be quite an in-depth piece of work for a particular condition, and I think we've mentioned the extensive work that was undertaken to design those pathways along with around 200 local clinicians and consumers. So health needs, I think, looking at prevalence of condition, demographics of regions, understanding socioeconomic disadvantage, really understanding those social determinants of health, and then the other component of work is really around how we plan and understand service gaps.

MR GLOVER: To the extent there are service gaps within primary care, perhaps in more remote parts of the district, is there a role for NSW Health to step in and provide those services where they're needed?

MS NEAL: Potentially.

THE COMMISSIONER: Who are you asking?

MR GLOVER: I'm sorry, I was still engaging with Ms Neal at the start. Sorry, I was looking at her, she was looking at me. It wouldn't have been clear to anybody else.

THE COMMISSIONER: It wouldn't come up for the transcript.

MS NEAL: Potentially, yes. I think we really need to consider - let me rephrase that. There are a whole range of considerations in taking that approach, and in my view, that includes considering how do we support the local market of primary care, ensuring that that is only done where there is market failure and there is an absence of those services available to communities.

In regional and rural communities, we experience very fragile provider markets, and we need to be very considered about initiatives or approaches to addressing those gaps, ensuring that they don't further exacerbate that fragility of the system, if you like, and we've seen, for example, in different policy areas, I will use NDIS as an example - we have the workforce that we have and, you know, there's often these push and pull factors, for example, where, you know - I'll just use the example of the allied health professional, they may be working in one part of the

system. That allied health professional may move somewhere else, you know, and remuneration is potentially a factor in that. So I think any approach of the state providing services really needs to consider the local primary care market and ensure that we work towards restoration of primary care services and, in particular, GP services, if that's the role, you know, or gap that the state is intending to fill.

The second part of that is, I think, the opportunity to look at models in terms of governance, such as, you know, we've used the example here of collaborative commissioning, but taking a joint approach, potentially between PHNs and LHDs, where we're looking at those gaps in service provisions in particular communities, and they do exist, but then thinking, you know, what is the best model that can be implemented to meet the needs of this community? I think a one size fits all approach is - you know, it probably will not work for a lot of our areas.

MR GLOVER: Ms Mills, do you have anything to add to that?

MS MILLS: No. I was just thinking of another example that we've just recently progressed is around urgent care services and, you know, having to consider, again, how we might do that in our region, whilst keeping in mind the sustainability of our local general practices, and, yes, we can understand the needs of community in terms of accessing urgent care, but also understanding our general practices and ensuring that they are part of the solution.

MR GLOVER: Can you just perhaps expand on the work that you have in mind when you are giving that answer? So what are the urgent care services that you have in mind and how are they being structured with the local GP market in mind?

MS MILLS: Sure. So urgent care services are currently being funded through NSW Health and through the ministry, and as part of our approach locally, initially, through the initial expression of interest that went out through the ministry, we went out to our general practices and said - you know, asked if any of the practices would be interested in delivering an urgent care service as a stand-alone service, and also provided an opportunity for people to express interest in a collaborative type model.

Now, we had no general practices in our Wagga region

that were interested in delivering a stand-alone service, and so what we've progressed in terms of primary care is looking at a collaborative model based on our - a similar model we have operating in the after-hours period, which is the Wagga GP after-hours service.

So for the Murrumbidgee region, the ministry is funding both an innovative model in primary care, and also through the rapid access clinic, through the local health district, with the intention for us to ensure that in the Wagga region, we've got an urgent care system that's made up of access to the rapid access clinic, our Wagga GP after-hours service that we operate, and also urgent care services in hours.

In terms of the model that we're developing in hours, it's really in its infancy. We held our first co-design session with GPs last week. That's looking at trying to bring together - you know, we've got about 20 or so general practices in Wagga, looking to bring together a cohort of practices who potentially can offer a couple of urgent care appointments per day which will be accessible through Healthdirect.

MR GLOVER: These are funded by the New South Wales ministry?

MS MILLS: So the funding will come from the ministry. At the moment we don't have that funding. We've received some, I guess, funding to co-design, and we've been quite clear, since the initiative started well over 12 months ago now, that for us to implement an urgent care service here in Wagga, we need to co-design that with our existing service providers, and really important that our GPs are part of that solution, not bringing in another stand-alone provider to deliver a service that could impact the viability of our existing providers.

So in terms of developing that, like I said, it's in its infancy, it is innovative. A lot of our practices, you know, obviously they've got their own patients, they've got their own waiting lists. For them to then go, "I'm going to hold a couple of appointments for urgent care to come through Healthdirect" is a big ask to get them to do that, but we've got a small number of practices that are willing to, for the benefit of the community, give it a go and see what they can design. So we're due to go back to the

ministry in April with a potential model, and for the ministry to fund that for another - for 12 months.

MR GLOVER: One of the considerations that Ms Neal referred to when I raised with her the prospect of NSW Health delivering some primary care services, where they may not be available, was, as you have just mentioned, the need to consider the existing market.

MS MILLS: Mmm.

MR GLOVER: If there is a situation where there is an existing primary care market, although it's not fully adequate to meet the needs of the local population, how might that be addressed without raising or running headlong into the concern that Ms Neal raised - that is, cutting across the viability of the market in that area?

MS MILLS: I think it goes back to Melissa's comment around that joint governance and not only joint governance but engagement of those providers as developing part of the solution. So that it's not the LHD or even the PHN, for that matter, coming in with, you know, "We're going to put this model in your community", without the GPs being part of that or, you know, whoever is in that community helping to design that.

I was just - you know, one of the services that we're currently designing, and it's not necessarily a GP service, but it's working with St Vincent's in Sydney to bring an endocrinologist and a diabetes educator down to some of our communities. We don't have an endocrinologist, a public endocrinologist, in the region, but as part of designing that model we've been quite proactive in working with those GPs to say, "Look, this is available, how do you think this could work? How do we ensure that you are engaged in that?"

MR GLOVER: From that answer, do I understand you to accept that the possibility that the market may need to be supplemented --

MS MILLS: Mmm-hmm.

MR GLOVER: -- but you, like Ms Neal, are of the view that that should only happen with the input and collaboration of the existing market, to the extent there is one, in that

particular area?

MS MILLS: Yep, and that would be from GPs to allied health, you know, your providers that are available.

MR GLOVER: Just pardon me a moment.

Ms Neal, I think in your time as CEO there was an agreement signed between the district and the PHN; is that right?

MS NEAL: That's correct.

MR GLOVER: Can you just tell us in general terms the purpose of that agreement and the aims that it seeks to achieve?

MS NEAL: The collaborative agreement formalises a longstanding relationship that we have had with the local health district and aligns our local approach with some of the more recent recommendations out of the joint statement work that I mentioned previously, which has been agreed by New South Wales PHNs and LHDs across the state, with the support of the relevant deputy secretaries.

That agreement really has a core focus of taking a one health system approach here in the Murrumbidgee, and there are three key areas that we focus on. So the first one is how do we optimise, if you like, the resources that we have available to us in the region; the second component is looking at how we trial new models of care and work on new models of care, and we have referenced some of those earlier; and the third area is really looking at that approach that we're progressing now around joint planning, information and data sharing.

MR GLOVER: When you described it as "a one health system approach", what did you mean by that?

MS NEAL: Yeah, I think we take the view of the patient or consumer here, if you need care, you don't walk into a health setting, you know, wondering if it's Commonwealth funded or if it's state funded or if there's another funding source, and for us here in the Murrumbidgee, that's what we mean by "one system". We take that view of the consumer.

If I'm in a community - and I'll use Lake Cargelligo, probably one of our more remote communities - and I have a health need, you know, what - how is that need met, regardless of who the funder is, and us ensuring that that is front and centre in all we do.

MR GLOVER: Are there any particular systemic barriers that you see to achieving that aim within the district?

MS NEAL: Yes, there is. I might start with, I think, data and information sharing. I can provide an example. You know, there are general communication issues, and we could potentially touch on those in a moment, around handover of care in particular of patients

MR GLOVER: Handover of care from whom to whom?

MS NEAL: From the acute system to primary care. But just focusing for a moment on data sharing, as one aspect, very early on in the collaborative commissioning, we have taken the view that we look, as we mentioned, at the whole pathway of care, and there were quite a lot of discussions with the Ministry of Health early on, who were really only focused on gathering data from the patient flow portal, see, that is an LHD-based system.

Now, ideally, if we're operating across an entire system and looking at early diagnosis and care in primary - delivery of care in primary care, optimal care of patients, there's a whole - a significant amount of work happening outside of the systems within the LHD environment.

You know, for some time - and I would say potentially several months, potentially up to eight months - we advocated quite strongly that, you know, we should not just be looking at data in terms of outcome purely from an acute system perspective, because the intent of the pathway is to direct people away from that acute system, and therefore, there is a whole range of data and information that is in the primary care setting that should be considered as part of the targets, if you like, or the success of that program.

So I think from a systems point of view, there is that need to consider what is the whole patient's journey, and I certainly can, you know, understand those pressures in the acute care system, but if we really want to determine

if an initiative is successful in achieving some of those broader system outcomes, we need to look at those data points across both of those settings.

MR GLOVER: So what can be done, in your view, to overcome that barrier?

MS NEAL: I think we've made a very small step, in that we're now gathering some of that data in work that is being undertaken in that primary care setting. There are still challenges with data sharing and consent processes, so as part of the work we need to build in those consent processes with the general practices to ensure that data can be shared with the LHD, for example, as part of the evaluation of that program.

So I think, you know, ideally, if there were interoperable systems or more connected systems, then you're able to track patients throughout the whole system.

MR GLOVER: That's not just data sharing from the primary care to the LHD, it's data sharing from the LHD back to the primary care setting as well; is that the idea?

MS NEAL: Yes. So for those chronic patients and complex patients ideally really understanding what is their journey through the whole system and where are those interventions having the most impact from a system perspective.

MR GLOVER: At the moment that's not visible across the patient cohort?

MS NEAL: No, it's not.

MR GLOVER: Are you familiar with the single digital patient record project?

MS NEAL: Yes.

MS MILLS: Yes.

MR GLOVER: What, if any, impact on the issue that you've just described will that have?

MS NEAL: The single digital patient record, I think the first challenge is - and PHN CEOs have met with New South Wales eHealth. I think the first issue is that we do not

yet know if and when there would be access to that system for primary care providers, and as I understand it, potentially that would be some time after implementation in the New South Wales system itself. There's certainly a willingness to have that discussion and I think that's a first step.

And as I understand it, that would be around view of information, which again might assist with things like handover of care in particular, between the system. The Commonwealth, although we don't have a lot of information at this point, is implementing an initiative under the more recent budget which is frequent hospital users, and, you know, we hope that there is some capacity to look at those patients' journeys through the system as well, and those patients will be involved in general practice. And the role in that initiative will be to LHDs and PHNs working together to identify those patients who are frequent hospital users, but we're really waiting for more information about what that looks like and that will be a longer term rollout.

So the short answer to your question is I'm not sure that the single digital patient record will necessarily solve some of those data sharing issues and that ability to measure outcomes in the system.

MR GLOVER: Ms Mills, did you have anything to add on the data sharing or lack thereof issue, before I move on?

MS MILLS: I don't think anything further. I think Melissa's highlighted some of the key issues, obviously one is the data - the single digital patient record will obviously, you know, once it's implemented, help with that provision of care, time and place, so --

MR GLOVER: Presumably if it is accessible to primary health?

MS MILLS: Yeah, so, you know, the GPs sitting there with their patient who has just come out of hospital, they'll be able to have access to what has gone on for them. At the moment, with lack of - and delays in discharge summaries, that impacts on continuity of care. So the hope is that single digital patient record will support that continuity of care for patients.

THE COMMISSIONER: But only if it is linked to primary care?

MS MILLS: Yes, only if it is linked to primary care, and that we're yet to see.

THE COMMISSIONER: I don't think that's the plan at the moment.

MS MILLS: Yeah. So there has certainly been some initial discussions with eHealth, which we had probably a month ago now, at the state CEO's meeting where we had an initial discussion around how can we look to get general practice as part of that program.

THE COMMISSIONER: What was the answer?

MS MILLS: Look, I think there's definitely an appetite for progressing that. I think what we need to do is to look at the feasibility of how that's actually going to work. You know, we need to understand what is that going to mean for a GP as well, and a GP in their practice in terms of, you know, logging in to the system, all of the realities of that.

So I think, you know, that's definitely an issue and, as Melissa was highlighting, particularly in - across a number of our programs, being able to share information between those models of care that are sitting within general practice and the acute system is quite clunky. There's intention and there's goodwill, but the reality of that is just not there.

MR GLOVER: In that answer you mentioned discharge summaries.

MS MILLS: Mmm-hmm.

MR GLOVER: If one were to assume that the single digital patient record would provide general practitioners with access to records from the acute care setting, it may provide more timely access to a discharge summary, but timeliness of access is just one of the issues with discharge summaries, is it not?

MS MILLS: Oh, the feedback that we get from GPs is also around the quality of the discharge summary as well and

issues there.

MR GLOVER: Ms Neal, in addition to the data sharing issue, are there any other systemic barriers that you see --

THE COMMISSIONER: Sorry, can I just ask, "quality" meaning more specifically not very helpful, I assume, but is there more than that?

MS MILLS: From what we, I guess, anecdotally hear from GPs, is it's, yeah, the quality of or the content of those discharge summaries.

THE COMMISSIONER: In what specific way?

MS MILLS: In terms of I think, you know, the details around changes to medication and things like that, that would - tests done.

THE COMMISSIONER: The important stuff.

MS MILLS: You know, the important things that GPs would need to be aware of that have occurred, and if that's not clear, you've sort of - you've got your GP --

THE COMMISSIONER: It's as good as nothing?

MS MILLS: Yes, yeah.

MR GLOVER: In that answer, you referred to some anecdotal reports as to satisfaction with discharge summaries from GPs. Are there any more formal measurements of --

THE COMMISSIONER: Discussions in committees, that sort of thing?

MR GLOVER: Yes, whether by surveys or committee discussions that you're aware of?

MS MILLS: Yes, so we have our clinical councils, so we've got four clinical councils that meet across our region. Look, I couldn't say that there's specific agenda items or things like that, that we would have noted. You know, I've been working in this space for a long time and discharge summaries just always seems to be an issue.

MR GLOVER: Are you aware of that being fed back to the LHD, either through your consultation with them or through that of your colleagues?

MS MILLS: Yeah, I think there's that - I would say there's a general understanding that have being an issue with the LHD. The LHD understanding that that is an issue, sorry.

MR GLOVER: Are you aware of any initiatives on the LHD side of the fence to address it?

MS MILLS: One of the initiatives that I can - that I'm aware of and can speak to is through our collaborative commissioning, we're about to commence on having someone through collaborative commissioning working potentially at the Griffith Base Hospital to look at what are the barriers or why are these discharge summaries not being completed.

MR GLOVER: That's in the context of the COPD and CHF cohort?

MS MILLS: Yes, I'm not sure if it's just going to be targeted to those particular conditions but because we often hear discharge summaries being an issue, through that collaborative commissioning, we want to see if we can at least understand what is happening within the hospital context as to why discharge summaries may be delayed or the quality might not be there.

So that's one that I know of. I'm not aware of any other specific strategies. From a PHN perspective we have recently undertaken some work with the LHD around ensuring that GPs are set up to receive electronic discharge summaries, so that it's not coming - being faxed and which - you know, a number of our practices were still receiving faxed discharges. So looking at working with our general practices to improve electronic uptake, which will also improve that, I guess.

MR GLOVER: And as you touched on in answer to the Commissioner, discharge summaries are an important issue in terms of the continuation of care for the patients once they return to the primary care setting; correct?

MS MILLS: Yes, yes.

MR GLOVER: Ms Neal, in addition to the information sharing issue that you raised, are there any other systemic barriers to achieving the one system approach aspiration of the agreement between the PHN and the LHD?

MS NEAL: Certainly the funding mechanisms, and we've touched on those, are a barrier to facilitating that, you know. In the examples that we've provided around, say, collaborative commissioning, they are funded initiatives. We have a whole range of other initiatives which we don't have that direct funding for, say from the Ministry of Health, but we feel are locally important, and enhancing paediatrics in primary care is an example of that, where the PHN and the LHD co-fund a position.

So I think there is a whole range of often funding restrictions within the system, and at the moment, to address local needs, it's really a bit of work to go, well, how can we leverage what we've got in the system to meet that need and reorientate what we have, and I think that ability is quite limited as well.

MR GLOVER: When you say "funding restrictions", are you talking about the size of the funding envelope or where it's coming from, what do you have in mind in particular?

MS NEAL: Yes, potentially flexibility. So if I use the example of enhancing paediatrics -

MR GLOVER: Just before you go into the funding side of it, just a brief explanation of what that program is and the PHN's role in it?

MS NEAL: Yes, so the enhancing paediatrics program is a joint-funded initiative where both the PHN and the LHD jointly fund a community paediatrician, and the aim of that is to provide support, to increase the capacity of primary care to provide assessments to children who are developmentally - who might be developmentally delayed or have behavioural issues.

The intent of the program is to increase that capacity in primary care, so it has very strong linkages to general practice. Narelle has led that program, so could go into that in more detail. The funding mechanism - the LHD and the PHN co-fund the community paediatrician. That is a 50:50 funding arrangement. And we identified that as

a particular area of focus through our local child and maternal health strategy, which was developed following the release of the First 2000 Days framework from the Ministry of Health. So I think it is a really good example where, you know, sometimes those funding - we didn't have funding, for example, to implement that initiative and we've managed to put together a program that has a really significant impact for families in our region who might otherwise face very significant delays to access that specialist care.

Those types of initiatives, you know, we're trying to leverage a 0.5 here or, you know, a bit of funding there. I think in regional/rural areas, we really need to have a more flexible approach to saying, "Okay, we have these needs in a particular community, how do we jointly utilise those funds to meet those needs?" At the moment, it is sometimes a little bit of scraping from here or there to get those funds together to deliver something to the community.

MR GLOVER: When you say more flexibility might be required, how might the flexible model work in your view?

MS NEAL: In my view it would be potentially, you know, I guess in a bit of an ideal world, that, you know, LHDs or regions - and I'm just going to speak from the rural and remote perspective - have some type of flexible funding or innovation pool where you might identify a gap or a particular need. To give you an idea, paediatrics in particular, we have really significant wait lists, I think up to around 12 months, for someone to see a paediatrician, a private paediatrician, in the region. This model was co-designed with GPs, with a local paediatrician. That type of flexibility in funding allows us to respond to needs, again, it's jointly governed, it has oversight, it involves GPs, community co-design. So it really is a targeted approach. So I think if there is any - you know, in an ideal world, in a future system, that there is some capacity for that localised response at an LHD level, you know, rather than - in that - I think, sorry, let me rephrase. I think that would allow the system to respond to needs in the future in a different way.

MR GLOVER: I'll just explore that with you to make sure I have understood the ideal flexible scenario as you would have it.

MS NEAL: Yes.

MR GLOVER: Do you have in mind a scenario where funding from - some funding from the PHN's envelope, some funding from the LHD's envelope, is put into a joint fund that could then be deployed as needed to meet the needs of the community on that joint governance basis that you have described? Is that what you have in mind?

MS NEAL: Yes, potentially, and I think it is probably a level above even the PHN and LHD. I think through mechanisms such as the National Health Reform Agreement, those opportunities to fund both, you know, via Commonwealth funding and those negotiations to identify those opportunities for more targeted regional planning, joint regional planning and service delivery under those flexible models where there are often very serious gaps - you know, I think in our region, we're dealing with people who, we have a lot of socioeconomic disadvantage, access and affordability is an absolute barrier to people accessing timely care, and those types of funding mechanisms, say through the National Health Reform Agreement, would you go some way to supporting, you know, I guess system change at a local level.

MR GLOVER: Do you have something to add to that, Ms Mills?

MS MILLS: Nothing more to add, but I was going to emphasise, too, that I think it has to be at that state level, where that commitment to joint governance and joint funding will --

MR GLOVER: The state ministry level and Commonwealth Department of Health level.

MS MILLS: Yes, through the reform agreements. That needs to be where it starts and drives that local ability for, at a local level, PHNs and LHDs to identify the needs and - you know, the needs for our region are going to be vastly different to the needs in Sydney, for example. But I think it needs to be driven at that stage.

THE COMMISSIONER: This is the part of the National Health Reform Agreement that talks about parties working together to better plan and coordinate health services, et cetera.

MS MILLS: Yes.

THE COMMISSIONER: In schedule C.

MS NEAL: Yes.

MS MILLS: Yes.

MR GLOVER: Thank you, Commissioner, that's all the questions I have.

THE COMMISSIONER: Thank you. Mr Chiu?

MR CHIU: No questions, thank you.

THE COMMISSIONER: Thank you both for coming. We're very grateful for your time and evidence. You are excused.

<THE WITNESSES WITHDREW

THE COMMISSIONER: And everyone is excused now, are they, until 10 o'clock tomorrow? We will adjourn until then, thank you.

AT 4.00PM THE COMMISSION OF INQUIRY WAS ADJOURNED TO WEDNESDAY, 20 MARCH 2024 AT 10AM

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