

**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**

Wednesday, 20 March 2024 at 10.00am

(Day 013)

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

1 THE COMMISSIONER: Good morning. Yes, Mr Glover.
2
3 MR GLOVER: Before we start with the next passage of
4 evidence, Commissioner, if I can take the opportunity to
5 formally tender the tender bundle for this hearing block,
6 which has been notionally marked exhibit C.
7
8 I hand up a list. That has had added to it the
9 document that was referred to by Mr Muston yesterday in the
10 passage of evidence from Dr Stephenson, so that's now in
11 evidence.
12
13 THE COMMISSIONER: I won't read through it. That can all
14 be noted as having the exhibits number and letter allocated
15 to it in this index.
16
17 MR GLOVER: Thank you, Commissioner. I call Tony Donoghue
18 and Councillor McCann.
19
20 <DAVID JAMES McCANN, sworn: [10am]
21
22 <ANTHONY GERARD DONOGHUE, sworn: [10am]
23
24 THE COMMISSIONER: Yes, go ahead.
25
26 <EXAMINATION BY MR GLOVER:
27
28 MR GLOVER: Mr Donoghue, if I can start with you, could
29 you state your full name for the record, please.
30
31 MR DONOGHUE: Anthony Gerard Donoghue
32
33 MR GLOVER: You are the general manager of the Coolamon
34 Shire Council?
35
36 MR DONOGHUE: Correct.
37
38 MR GLOVER: How long have you held that role?
39
40 MR DONOGHUE: Since 2014, so coming on 10 years.
41
42 MR GLOVER: Councillor McCann, you're the mayor of the
43 shire?
44
45 MR McCANN: That's correct.
46
47 MR GLOVER: Can you just state your full name for the

1 record, please?
2
3 MR McCANN: David James McCann.
4
5 MR GLOVER: How long have you been the mayor?
6
7 MR McCANN: For three years.
8
9 MR GLOVER: Have you been on council for a longer period
10 than that?
11
12 MR McCANN: Since 2008.
13
14 MR GLOVER: Mr Donoghue, if I can start with you, could
15 you tell us a little bit about the shire?
16
17 MR DONOGHUE: Yeah, Coolamon Shire is half an hour north
18 of Wagga. We're a predominantly rural based shire. We've
19 got 4,350 people within that shire, we've got six
20 communities spread over quite a large area of road network.
21
22 MR GLOVER: And are there any particular features of the
23 population within the shire?
24
25 MR DONOGHUE: Well, we are an ageing population. We have
26 a housing shortage currently, as across most of the state,
27 we're having. We're normally - I won't say "normally". We
28 are a dormitory suburb of Wagga, really, a lot of people
29 work in Wagga but then there's a big rural community.
30 That's the basis of our economy, is the rural production.
31
32 MR GLOVER: Councillor McCann, do you wish to add
33 anything?
34
35 MR McCANN: No. That pretty much sums it up, just
36 emphasising the fact that the six communities that we do
37 have are three towns and three villages, so the dynamic of
38 each of those communities is quite different but
39 collectively come together in the Coolamon Shire.
40
41 MR GLOVER: Mr Donoghue, are there any features of the
42 demographic within the shire that have, to your
43 understanding, presented some challenges in the delivery of
44 health services?
45
46 MR DONOGHUE: Well, by being that spread, we have to have
47 replication of services across more communities and we have

1 an ageing population that historically, prior to us
2 stepping into the aged care facilities space, was being
3 dispersed and going to other communities, and that was
4 breaking up our community by not looking after our elderly.
5 So that continues to this day.

6
7 MR GLOVER: I will come back to what the council is doing
8 in that space in a moment --

9
10 MR DONOGHUE: Mmm-hmm.

11
12 MR GLOVER: -- but what you're describing there is the
13 need for residents of the shire to travel outside the shire
14 to obtain the care they need; is that what you're referring
15 to?

16
17 MR DONOGHUE: Correct. So our dormitory space to Wagga
18 meant that services are needed for us to grow our community
19 and ensure that our community is looked after. So one of
20 those is aged care and health care and one of those is
21 child care. It's - you know, if people are working in
22 Wagga, they need someone to look after their kids.
23 Similarly as people age, they want to live in their
24 community. They're the services we sort of step in to
25 provide.

26
27 MR GLOVER: What is the council doing in terms of
28 delivering health care services to its population?

29
30 MR DONOGHUE: We own and operate Allawah Lodge, which is
31 a 33-bed hostel. We also have 25 self-care units, called
32 Allawah Retirement Village. We have a healthcare precinct,
33 which we own, all of the land within that, and within it is
34 the hospital, the MPS. We have a doctor's surgery with
35 room for four doctors and two dentists.

36
37 We run our home care packages out of our Allawah
38 Community Care, so we do Meals on Wheels, travel
39 assistance, care, in-home care. We have the ambulance
40 station located in it. We have allied health
41 professionals, a building associated with them, for such
42 things as physios, mental health spaces, all that sort of
43 stuff.

44
45 We also have, not in that precinct but we have 20
46 low-income aged care housing. So that's for people who are
47 in between the pension and superannuation, there's that -

1 there's a little gap of people there that still need to be
2 housed.
3
4 MR GLOVER: I'll come back to aged care services in a
5 moment but we'll just explore the precinct a little.
6 That's a facility that is owned by the council; correct?
7
8 MR DONOGHUE: Correct, yep.
9
10 MR GLOVER: And does the council itself deliver services
11 in that precinct?
12
13 MR DONOGHUE: Yes.
14
15 MR GLOVER: Or is it leasing out the premises to other
16 providers?
17
18 MR DONOGHUE: We own and operate and manage everything
19 except - well, when I say "everything", I'll give you the
20 exceptions, maybe.
21
22 MR GLOVER: Yes.
23
24 MR DONOGHUE: We don't run the MPS, that's run by the
25 health department. We gave 100 grand and the land for the
26 ambulance station but they run their own facilities there,
27 the health system, and the doctors and the dentist is
28 a lease for them to run their business out of our building.
29
30 MR GLOVER: Is the precinct an important part of the
31 council's work in its region?
32
33 MR DONOGHUE: It's critical.
34
35 MR GLOVER: Why?
36
37 MR DONOGHUE: It provides the health that our community
38 needs, the health services that our community needs.
39
40 MR GLOVER: You've mentioned in some of your earlier
41 answers the role of the council in aged care, one of them
42 being Allawah Lodge. Can you just describe the lodge to
43 us, please?
44
45 MR DONOGHUE: Do you want me to give some historical
46 context?
47

1 MR GLOVER: Yes, please.
2
3 MR DONOGHUE: Originally, in the '90s, there was talk of
4 the hospital closing. In early '91/'92, there was
5 a committee set up to save the hospital. It then turned
6 into the Allawah Lodge committee that then built Allawah
7 Lodge. Originally it was 12 rooms, in '93. I think in '97
8 we put in another 10, which got it to 22. In 2004 we got -
9 the dementia needs were increasing as aged care was
10 changing from pretty much self-care, hotel-style
11 arrangements, to a higher care need, and more people with
12 significant care needs, so we built the dementia wing,
13 which was another 11 beds, so that's how we got to, in
14 2004, 33 beds.
15
16 MR GLOVER: And this is a residential aged care facility;
17 correct?
18
19 MR DONOGHUE: Correct.
20
21 MR GLOVER: Owned and operated by the council?
22
23 MR DONOGHUE: Yes.
24
25 MR GLOVER: Has it always been owned and operated by the
26 council?
27
28 MR DONOGHUE: Yes.
29
30 MR GLOVER: How does the council fund that operation?
31
32 MR DONOGHUE: Initially the funding was done by community,
33 bequeathments and fundraising, as things were done back
34 then. It's now run as a commercial operation and the same
35 way any other aged care facility gets funding through the
36 health - the federal government, we chase grants where we
37 can and we manage to keep operating it. It's basically
38 become welded on to our operation, because of the
39 importance of it, and because of how the community see it
40 as a critically important --
41
42 MR GLOVER: When you say it has been "welded on" to the
43 operation, do you mean it has become part of the ordinary
44 business of your council?
45
46 MR DONOGHUE: Correct. I know that other councils had
47 similar facilities but sold them off. I think we're down

1 to nine councils that still have those facilities.
2 Predominantly, the rural and regional areas, where if that
3 service is not there, we jump into that space and take it
4 on.

5
6 THE COMMISSIONER: So do I understand that this way, the
7 council owns the building that is Allawah Lodge?

8
9 MR DONOGHUE: Correct.

10
11 THE COMMISSIONER: And that was paid for by bequests and
12 fundraising and some council funds as well?

13
14 MR DONOGHUE: Yes, council funds, correct.

15
16 THE COMMISSIONER: And the staff there are employed by the
17 council?

18
19 MR DONOGHUE: Correct.

20
21 THE COMMISSIONER: But the federal government pays
22 whatever it pays for the occupation of the beds?

23
24 MR DONOGHUE: Correct. So one of those - an example of
25 that is they are employed under our award, which is
26 different to the federal health care award. So as of
27 yesterday, the announcement of an increase for healthcare
28 workers applies to the feds but does not apply to us. So
29 we have to now manage that difficult situation where people
30 will either migrate to a higher paying job or we have to
31 manage paying above award so that we can maintain that
32 workforce.

33
34 THE COMMISSIONER: I think Mr Glover will probably explore
35 that with you.

36
37 MR GLOVER: Yes, now is a convenient time.

38
39 MR DONOGHUE: Sure.

40
41 MR GLOVER: You've highlighted in that answer some of the
42 differences, in terms of workforce issues, in particular,
43 how staff of paid, between those employed in Commonwealth
44 or state-run facilities and the council. Are there any
45 other challenges that the council faces in terms of
46 employing and retaining staff in - we'll deal with Allawah
47 Lodge for the moment?

1
2 MR DONOGHUE: Yes, getting nurses into the aged care
3 sector is a challenge, and there's several factors that
4 relate to that.
5
6 MR GLOVER: Let's step them through. What are the
7 challenges that the council faces in recruiting and
8 retaining nurses to staff Allawah Lodge?
9
10 MR DONOGHUE: The first one is the state health system
11 has - to encourage nurses to come to regional areas, pays
12 a \$20,000 incentive for them to come. So when we put an ad
13 in the paper, you know, why come to us when you get \$20,000
14 extra just to turn up out of the city? The second issue is
15 around --
16
17 MR GLOVER: Just before you move to the second, that's an
18 incentive that the state government offers, but the council
19 is unable to offer?
20
21 MR DONOGHUE: Well, we could, but it would run us broke.
22 There's a cost to that.
23
24 MR GLOVER: Quite.
25
26 THE COMMISSIONER: It's an incentive offered specifically
27 for aged care nursing, is it, or --
28
29 MR DONOGHUE: The state --
30
31 THE COMMISSIONER: The 20,000 that you are mentioning.
32
33 MR DONOGHUE: It is for nurses in the - I think it's just
34 general nurses in the health system.
35
36 MR GLOVER: So is the point you're raising there, to match
37 the offer from the state would create a significant
38 financial burden on the council?
39
40 MR DONOGHUE: Yes. It would. Yes.
41
42 MR GLOVER: I interrupted you. You were going on to
43 another one.
44
45 MR DONOGHUE: Yeah, now, I've forgotten my point, I'm
46 sorry.
47

1 MR GLOVER: We were exploring a number of challenges you
2 face in recruiting and retaining staff in Allawah Lodge.

3
4 MR DONOGHUE: Yes.

5
6 MR GLOVER: You said there were a number and then
7 I invited you to take it step by step. The first one you
8 raised was the issue of the incentive, so the state
9 government offers the incentive which would place the
10 council in a difficult financial position if it were to do
11 the same.

12
13 MR DONOGHUE: Yeah.

14
15 MR GLOVER: Are there any others?

16
17 MR DONOGHUE: The difference between the awards, and some
18 components of that are better in ours than in theirs but it
19 doesn't matter; they want to - they would rather a level
20 playing field, you know.

21
22 MR GLOVER: What difference is in the state award that is
23 not in the council award?

24
25 MR DONOGHUE: Well, one of the examples was --

26
27 MR GLOVER: Sorry, I said "state". I think I should have
28 meant "Commonwealth".

29
30 MR DONOGHUE: I don't know exactly which one it is but the
31 complaint we were getting from some agency staff that we
32 were getting was that our 11 o'clock shift started 11am,
33 because it started pre-lunch, they were getting more, than
34 the agency staff would have been getting because of their
35 award system, but the agency staff get far more on all
36 other aspects of the award. So that's the little bit of,
37 you know, trying to pick exactly which one is to your
38 advantage to see if they can be paid more. But from our
39 perspective, an agency staff is already three times the
40 price of our normal staff anyway. So it is only a case of
41 last resort.

42
43 MR GLOVER: All right. Any other challenges in bringing
44 and retaining staff?

45
46 MR DONOGHUE: You'll have to leave that with me. Can
47 I come back to it? It will strike me.

1
2 MR GLOVER: Of course. Reflect and if it comes to you,
3 you just let me know.

4
5 THE COMMISSIONER: Is it in the outline anywhere?

6
7 MR DONOGHUE: Yeah, I think - I'd have to read that.

8
9 MR GLOVER: Councillor McCann, did you have anything to
10 add to that passage of evidence?

11
12 MR McCANN: No, just probably to reinforce the point that
13 it's important that it's understood that local government
14 in rural and regional areas is - whilst it's often said
15 councils are about roads, rates and rubbish, in rural and
16 regional New South Wales, if we were to apply that rule in
17 the Coolamon Shire, we would have the best roads, the
18 lowest rates and the quickest garbage collection in the
19 state, but we wouldn't have the services that we have in
20 our community now, particularly in the health area and aged
21 care, which are obviously why we are here today.

22
23 But it's the lack of understanding, I think, by the
24 state government and higher, even to the federal level, of
25 the role that local government plays in the provision of
26 health services in rural and regional New South Wales.
27 It's very easy to say it's being provided by NSW Health,
28 et cetera, but as Tony's outlined in his evidence there,
29 issues like an ambulance - we didn't have an ambulance in
30 the Coolamon Shire.

31
32 Now, we're 40 kilometres from Wagga. People would
33 argue why do you need an ambulance, but part of our shire
34 is Ardlethan, which is further 70 kilometres further north
35 of Coolamon, so we're talking a hundred-kilometre distance.
36 We have the Newell Highway in our shire. We have an
37 extensive rural and regional road network. So the need for
38 an ambulance was quite critical, plus the fact we have an
39 ageing population and the need that they had for an
40 ambulance.

41
42 So rather than council just sitting on its hands, we
43 were very proactive working with NSW Health and NSW
44 Ambulance to get an ambulance station in Coolamon. That
45 now services our shire. It supports Junee, Narrandera and
46 Wagga. Actually our ambulance - when I say "our
47 ambulance", the Coolamon ambulance, is required to come in

1 to Wagga to support the crew in Wagga as situations arise.

2
3 So I guess where I'm coming from is that it's not
4 recognised that local government is doing a hell of a lot
5 in this space. I'm not here to argue for financial
6 remuneration or anything like that, but an understanding
7 that local government is buying the land that hospitals are
8 built on; it's putting in the infrastructure to allow
9 NSW Health to develop their facilities. But we're not
10 getting - we're not being either acknowledged and we're not
11 being involved in the conversations as to where and when
12 these things should happen.

13
14 THE COMMISSIONER: Does the same argument apply to the
15 Commonwealth in relation to how the council and the
16 community have had to step in to create Allawah Lodge?

17
18 MR McCANN: Absolutely, yes. I believe that there's not
19 an understanding of the philosophy that - again, as Tony
20 said, if a service isn't available in a rural community,
21 and it's not cost effective - if I use the aged care as an
22 example, it's not cost effective for an aged care provider,
23 a private provider, to come into Coolamon and take over
24 that facility, they would not see the value in it.

25
26 But for us as a community, it's where our elderly
27 people go, and Allawah Lodge is now pretty well, safe to
28 say, an end of life facility. It has changed, the dynamic
29 of the facility has changed over the years. So if we
30 weren't providing that, the only place for those people to
31 go would be into the health system in New South Wales, and
32 that would block up the aged care system within NSW Health,
33 in the hospital.

34
35 THE COMMISSIONER: It would also take those people away
36 from their families and friends.

37
38 MR McCANN: Absolutely, Commissioner. That's crucial to
39 us, to allow people to live gracefully in the community
40 where they've basically given their sweat and blood for
41 many years. So to us, it's crucial and it's a vital part
42 of our operations.

43
44 MR GLOVER: So if I can just unpack that a little bit,
45 there are a few concepts you've raised there. The first
46 is, where there's a lack of service in the shire, you see
47 it as important, as council, stepping in to provide that

1 service; correct?

2

3 MR McCANN: That's correct.

4

5 MR GLOVER: And Allawah Lodge is an example?

6

7 MR McCANN: Well, Allawah Lodge, and also the home care
8 and those other sorts of allied health services that come
9 from our community care centre.

10

11 MR GLOVER: Secondly, there's advocacy for the people of
12 the shire within existing health structures, be it state or
13 Commonwealth, that's an important part of the work of the
14 council?

15

16 MR McCANN: Very much so, yeah.

17

18 MR GLOVER: Thirdly, the provision of the infrastructure,
19 like the health precinct?

20

21 MR McCANN: And a good example is our current situation
22 where the Murrumbidgee Local Health District has identified
23 the Coolamon MPS as a piece of infrastructure for upgrade.
24 Prior to the last state election there was a promise, if
25 I can use that word, of \$50 million to revamp that
26 facility. That would increase the bed numbers to something
27 like 33, 34 health beds.

28

29 Whilst that's not primary - well, it'd be located in
30 Coolamon, but the thing that attracted me and council to
31 the idea was that Murrumbidgee health came up with a very
32 innovative way of developing the MPS in what they were
33 calling a "hub and spoke model" for health provision, so
34 that hospitals like Coolamon would be there, would allow
35 people from the north of the shire, from north of Wagga, to
36 come to Wagga to receive critical care in the hospital and
37 then be moved back to Coolamon to recover and then onwards
38 to their home.

39

40 We were very keen to see that develop. Unfortunately,
41 the funding was not made available. We understand we're
42 still the first - or the priority job for Murrumbidgee
43 health, and we will continue to advocate for that strongly.
44 But as part of that, we intend to purchase the land that
45 that MPS will be built on, because the current MPS, which
46 is a state-run facility, is actually built on council land.
47 We don't get into the sort of mud of fighting about paying

1 money for that, it's there, it's built on an extra service
2 to the community, so we give that, and we will do the same
3 with the land that we will purchase for the new MPS should
4 that comes along, as we did with the ambulance service. So
5 we're committed to providing the space for health services.
6

7 MR GLOVER: Mr Donoghue, could I ask you a couple of
8 further questions about --

9
10 MR DONOGHUE: Do you want me to - I've remembered.

11
12 MR GLOVER: Yes, do it now.

13
14 MR DONOGHUE: It was the tax advantages that the health
15 system can offer its employees that we don't have access
16 to. I'm understanding that the state health system, and if
17 you are a registered charity, you get tax advantages on
18 pre-tax dollars, where we can't offer that. So every time
19 we're trying to negotiate a price with someone to come work
20 for us, they require a higher price because we have to
21 match that tax free component.
22

23 MR GLOVER: So there are benefits that the state can offer
24 and registered charities, who may be affiliated health
25 organisations, can offer --

26
27 MR DONOGHUE: Correct.

28
29 MR GLOVER: -- to attract staff, that are not available to
30 you as a council to offer; correct?

31
32 MR DONOGHUE: Correct, yeah.

33
34 MR GLOVER: And the impact of that is, when you are trying
35 to perhaps match like for like, it will cost, in real
36 terms, the council more to do that. Is that the issue
37 you're raising?
38

39 MR DONOGHUE: Correct. And I'll add one more little bit
40 to that, which is around responsibility. Like, when you're
41 a nurse in the health system - and I'll use the example of
42 Coolamon hospital compared to ours - is that you have the
43 support of a doctor on call, 24 hours on call, so if
44 there's an incident or something that requires attention,
45 you can get that support immediately. There are - I think
46 there's 15 ENs/RNs in a 12-bed health system in Coolamon
47 for the state system, whereas we've got 33 beds, we've got

1 one RN and we don't have 24-hour support. So there's
2 a weight on the shoulder of an RN without that level of
3 support that the health system provides their nurses.

4
5 MR GLOVER: So what could be done in that scenario to
6 alleviate that burden?

7
8 MR DONOGHUE: I would hope - in our case, we are right
9 next door to the hospital, by a door, nearly - that that
10 support would be extended. How that is paid for I'm not
11 sure. Because we're an MPS, the health system pays for
12 a certain component but the federal government pays another
13 component, because of the MPS, of every visit. So it's
14 that confusion of three tiers of government providing
15 a service and paying for it differently out of different
16 pockets of money.

17
18 MR GLOVER: And do you see that as creating barriers to
19 the operational function of those facilities?

20
21 MR DONOGHUE: Correct, yeah.

22
23 MR GLOVER: If I can just take you back to the health
24 precinct for the moment --

25
26 THE COMMISSIONER: We might need, not now, but the
27 details, the break-up of fees providing in terms of
28 funding?

29
30 MR GLOVER: Yes.

31
32 So the health precinct you described earlier, and it
33 has space for allied health providers, doctor, dentists, in
34 addition to the MPS; correct?

35
36 MR DONOGHUE: Correct.

37
38 MR GLOVER: And some of those facilities are leased to
39 third party providers; is that right?

40
41 MR DONOGHUE: Yes, the medical facilities are.

42
43 MR GLOVER: Does the council offer incentives for those
44 providers to take up space in that facility?

45
46 MR DONOGHUE: We have. So it's not only just in Coolamon,
47 there's also a facility in Ganmain that's linked to that

1 Please so that they can visit Ganmain as well as Coolamon.
2 We have supported them with immigration support for doctors
3 to come out here. We have built a house for doctors. The
4 current doctor has bought that back off us, which has been
5 very - we're very happy with that, like, that's an
6 investment that they're making in our community, which is
7 what we're after all along.

8
9 Yet we - that support can come in many varied
10 requests, and we consider them all, what's appropriate, but
11 we always try to have in the back of our mind that we would
12 like those doctors to invest in our community and live in
13 our community, because that's the ideal outcome, is that we
14 don't have to subsidise anything, it runs efficiently on
15 its own.

16
17 MR GLOVER: As a starting point, to attract doctors and
18 nurses --

19
20 MR DONOGHUE: Yes.

21
22 MR GLOVER: -- the council offering incentives and support
23 to attract them to the region?

24
25 MR DONOGHUE: Yes.

26
27 MR GLOVER: By way of housing support?

28
29 MR DONOGHUE: By way of housing support.

30
31 MR GLOVER: Anything else?

32
33 MR DONOGHUE: Accommodation, subsidised rent for the
34 facility. We manage all the - any problems they've got,
35 they ring us and we have a discussion about it.

36
37 THE COMMISSIONER: The general practice and dental rooms
38 that are mentioned in the health precinct, in paragraph 3
39 of your outline, it's one GP, is it? Or more?

40
41 MR DONOGHUE: We have two GPs at the moment. They are
42 currently negotiating for a third to return, so we gave
43 some immigration support to the gentleman who was with us
44 for six months, a year, and then he left, but he's thinking
45 of coming back, and then there's a third - sorry, a fourth
46 doctor who's pending. We don't know exactly yet, but we
47 are trying to facilitate that accommodation.

1
2 THE COMMISSIONER: It says "dental rooms". Does that mean
3 there's a dentist there?
4

5 MR DONOGHUE: Yes. So we lease the entire building to the
6 doctors, and then they sub-lease it to the dentist. When
7 we first set it up, we - so when was that? Dr Peter
8 English came late '90s. His wife was a dentist. So the
9 agreement was that we would build four doctors' visit rooms
10 and two dental rooms. They've moved on and left us, but
11 that's the agreement we then came up to make sure we
12 maintained a dentist and a doctor.
13

14 MR McCANN: I think it's probably worth saying, too, that
15 as a council, we are very receptive to meeting the needs of
16 the doctors as they ask them. And it has been questioned,
17 when do we put a line in the sand, so to speak, to say that
18 we can't go any further, and there have been occasions
19 where we've gone close to that line but we always - as
20 a council, collectively and with the community interest at
21 heart, we usually find that we bend and find a way to
22 achieve what is needed.
23

24 We had a situation where the doctors provided
25 a medical service to Ardlethan, which I said was to the
26 north of our shire. They determined that it wasn't cost
27 effective for them to be travelling up to Ardlethan to do
28 that, which effectively meant that that community would
29 lose its regular doctor service, and they would have to
30 travel to Coolamon, and whilst that is probably not -
31 doesn't seem hard, perhaps, for someone from the
32 metropolitan area, for the people who needed the doctors in
33 Ardlethan, it was quite a significant burden to ask them.
34

35 So from a council point of view, we were fortunate
36 that we were able to negotiate a settlement, due to Tony's
37 relationship with the doctors there, but had they not, we
38 would have had to have looked, then, at how do we get those
39 people --
40

41 THE COMMISSIONER: What's the distance between the town --
42

43 MR McCANN: It's about 70 kilometres.
44

45 THE COMMISSIONER: What was the settlement, some sort of
46 travel cost, was it?
47

1 MR McCANN: No, they have decided that it's now - because
2 they're getting a third doctor, who is a junior doctor,
3 that he can travel to Ardlethan.
4

5 MR DONOGHUE: There were some travel costs through the
6 19(2) exemptions, because it's an MPS, and because we also
7 do community care, we see the responsibility of getting
8 those elderly into Coolamon, so we see an increase on our
9 service needs. We either increase the doctor going out
10 there to meet them or we have an increase on our needs
11 coming in, and that's a volunteer-based system, so it
12 creates headaches on how do we get people in here. They
13

14 Were making commercial decisions, you know, an hour
15 out is four patients they don't see, they go out for the
16 hour, they see eight patients, there's another hour back
17 in. So they are weighing up their commercial needs,
18 whereas we're weighing up, well, we've got to get those
19 elderly around somehow. It comes off our bottom line or
20 our work list or work tasks somewhere.
21

22 MR GLOVER: That's an example, Councillor McCann, of what
23 we spoke about earlier where there's a need to retain
24 services within the shire and the council has stepped in to
25 do what it can to ensure that occurs; correct?
26

27 MR McCANN: Absolutely, yes.
28

29 MR GLOVER: And that comes at a cost to the council?
30

31 MR McCANN: Yes, it does.
32

33 MR GLOVER: Does it receive any funding support to achieve
34 that aim, whether from the state or the Commonwealth?
35

36 MR DONOGHUE: I need to be careful how I say that, whether
37 it costs the council. I am conscious that our ratepayer
38 should not be subsidising our health system. So we try and
39 manage each of those independently. So Allawah Community
40 Care, Allawah Lodge run completely separate books, because
41 they are different businesses, and they are differently
42 funded, but our aged care and our healthcare sector, I try
43 to run as a non-impost on the ratepayer money, because
44 that - a ratepayer shouldn't happen to be paying their
45 rates to have the health system sorted.
46

47 So, for example, Allawah Lodge used to make a lot of

1 money under two-funding-agos model. Then we moved to the
2 ACFI. The ACFI drained us and we were losing money, but
3 the Allawah village would make money with differing levels,
4 and so I would try and subsidise it all in that healthcare
5 bundle as opposed to a council contribution through its
6 rates - ratepayers.

7
8 MR GLOVER: I was going to do this towards the end but it
9 seems a convenient time to do it now. I just want to step
10 through with you each of the facilities and services that
11 the council is involved in and explore with you how they
12 are funded.

13
14 So if we start with the lodge, which you just
15 described as one of the services that you try your best to
16 run as a stand alone entity without drawing on the
17 resources of council --

18
19 MR DONOGHUE: It is federally funded and it is now under
20 the AN-ACC model, and that AN-ACC model - the ACFI was
21 really based on care needs and you got paid for the care
22 required per patient. Now, that is really difficult to do
23 in a rural community where it - I'll say in a higher
24 population area, you just take the higher needs people.
25 You just say, "Well, look, if I'm going to get \$200 for
26 that person, that's who I take." Whereas we have to take
27 people - we have to take people going in to getting more
28 care needs, so there's an - we take in the lower level and
29 then they escalate so that by the time they get to where
30 they're worth the most to you as an organisation, is then
31 not far off leaving us.

32
33 MR GLOVER: When you say "worth the most", you mean
34 attract the higher rates of funding?

35
36 MR DONOGHUE: Correct, attract the highest funding income
37 but they're there for not a very long period of time
38 because they're at a closer point to leaving us. But if
39 you waited for everyone to be at that level, then you're
40 not looking after your community because all the people who
41 need that - it's the number of beds you've got.

42
43 So there's also a 40 per cent subsidy if you have
44 people who are on lower income, so you're making judgment
45 calls every time you've got a vacant bed on whether you
46 need to be at a 40 per cent subsidised level as an
47 organisation or whether you need the higher person in your

1 bed to attract the income. So you're juggling that all the
2 time to make money. And under the ACFI that wasn't - it
3 wasn't working, because you've got to - when you've got
4 everyone at the highest need, you have a higher workforce
5 need. When you have everyone at the lower need, you have
6 a lower workforce need. But people want a job. They want
7 a job to pay a mortgage. So they can't come to work and
8 not go to work --

9
10 MR GLOVER: This is the previous model you're referring
11 to?

12
13 MR DONOGHUE: This is the ACFI model. Now we've moved
14 into the AN-ACC, which has a base bed rate and then a care
15 model, and that's a far better funding model for us at
16 Allawah for a regional, rural space, because you want to
17 give continuity of the job to people.

18
19 MR GLOVER: Under that model, have you been able to
20 achieve your aim of having that run as a self-sustaining
21 service without needing to draw on the resources of
22 council?

23
24 MR DONOGHUE: I will say we've turned the corner. We have
25 not fixed it yet, because our fix requires a workforce. So
26 in - just around the COVID time, we had to shut 11 beds
27 because we did not have the workers available to do the
28 work. So we have had to subsequently go and enter into an
29 agreement with Groworx, which is a Philippine based - and
30 we've brought out 11 care workers currently. I've got
31 another four I hope to have out by the end of this year
32 again - or, sorry, the end of this financial year. So that
33 will be 15 workers. That's cost us, oh, 250 grand. But
34 because we didn't have the workers and we had to shut the
35 beds, we were paying 400 grand in agency staff, so we
36 took - we bit the bullet. We've got to recoup all that, is
37 what I'm trying to - I'm giving you a very long-winded
38 answer to say we've got to recoup a lot of cost to get
39 there.

40
41 MR GLOVER: It is on the pathway?

42
43 MR DONOGHUE: That's right.

44
45 MR GLOVER: But you see light on the horizon; is that
46 fair?

47

1 MR DONOGHUE: I see the light getting bigger in the
2 horizon, yes.
3
4 MR GLOVER: In that answer you mentioned recruiting some
5 overseas qualified nursing staff; correct?
6
7 MR DONOGHUE: Yes.
8
9 MR GLOVER: Have you needed to do that because you haven't
10 been able to recruit locally?
11
12 MR DONOGHUE: I've been trying to advertise for RNs for
13 seven years and I have one RN. That RN is - we put her
14 through, as a care worker, and educated her, and she stayed
15 with us, which is great, but I've had not a real lot of
16 success getting RNs in to regional areas.
17
18 MR GLOVER: What have you observed the barriers to be to
19 getting people to respond to those recruitment drives?
20
21 MR DONOGHUE: The aged care commission did a very good job
22 of finding - weeding out the bad --
23
24 MR GLOVER: The Royal Commission?
25
26 MR DONOGHUE: The Royal Commission. Sorry, the Royal
27 Commission, but it didn't put aged care in a shining light
28 and there was a period there when morale was low and being
29 in aged care was not seen as a positive path to take in
30 your career, so that was definitely a negative side to it.
31
32 We had a few staff come to us from the health system
33 that we got, that - and as I mentioned earlier, that
34 hierarchy of decision-making and protection, they didn't
35 like that at all. And aged care is a specialist - it's
36 a bit like someone who's in the theatre, a theatre nurse,
37 they like that, that's what they do. There's not a big
38 call for aged care.
39
40 MR GLOVER: In addition to the challenges that you have as
41 a council in matching packages that are available in other
42 systems; correct?
43
44 MR DONOGHUE: As I said earlier, the payment structure
45 that we deal with.
46
47 MR GLOVER: Can I ask you a little bit about the Allawah

1 Retirement Village, which you touched on earlier?
2
3 MR DONOGHUE: Yes.
4
5 MR GLOVER: They're self-care units, are they?
6
7 MR DONOGHUE: Yeah, they're two bedroom self-care units.
8
9 MR GLOVER: How many are there?
10
11 MR DONOGHUE: Twenty-five.
12
13 MR GLOVER: That is a facility constructed and owned by
14 council; correct?
15
16 MR DONOGHUE: Yep. So after we built Allawah Lodge, it
17 was originally built with carports. So here is an example
18 of the naivety, that we were worrying about people driving
19 to and from the lodge. As people were using it for later
20 in life and for longer periods, it was quite obvious that
21 it was not a hostel, and so we built two-bedroom units for
22 people to move in off the farm, basically - sell the farm,
23 move in to town, be looked after, cared for and it was
24 a loan licence model.
25
26 Initially, Allawah Lodge, the lodge paid for the start
27 of those constructions, and then that built the capacity
28 for it to just keep growing. I think we did seven
29 originally, and then we put five and then - et cetera,
30 et cetera. And they've been utilised ever since we've had
31 them there, and they sort of - I'm going to say
32 "cross-subsidised" but that's not the right word. They
33 help us back the financial model that we need to have for
34 the Allawah Lodge when it's needed.
35
36 MR GLOVER: How are the services in the village funded?
37
38 MR DONOGHUE: User pays. So it is - you pay a - you lodge
39 a bond. The bond is then - you take 30 - the maximum you
40 can take off them is 30 per cent out of the bond, but we do
41 it over a 6 per cent - 6 per cent, 5 per cent, 5 per cent.
42 So it's over years. So if you're there for 10 years, after
43 that, it's for free, basically. You do pay an annual
44 amount of \$100 a week and that covers power, water - no,
45 sorry, not power. Water, rates, gardening, anything else,
46 other than power and phone are the only thing they pay for.
47

1 MR GLOVER: Does council receive any funding from either
2 state or federal government to support that operation?

3
4 MR DONOGHUE: No. We live off the interest that that -
5 those bonds that are held, and can I sort of explain,
6 that's part of the problem we were in with the ACFI
7 problem, like, pre-2019, because it was such an
8 interest-based model, both the Allawah Lodge and the aged
9 care - self-care units, that that was a period of time when
10 our books didn't look as good because the interest rates
11 were at practically zero. If you went back, you know,
12 pre-2016, the books looked a lot better because the
13 interest rate is what you're living off.

14
15 MR GLOVER: Like in the circumstance of the lodge, has
16 that improved in recent times?

17
18 MR DONOGHUE: It has because we're now moving away from an
19 interest-based model.

20
21 MR GLOVER: You mentioned, Mr Donoghue, in some earlier
22 evidence, community care services provided by the council.

23
24 MR DONOGHUE: Yes.

25
26 MR GLOVER: Can you just tell us what they are?

27
28 MR DONOGHUE: So we do home care packages, we do CSHP,
29 which is basically community care. So that can be a model
30 of, you know, you get your lawn-mowing done; you can get
31 someone coming around to make sure you take your tablets at
32 the right time; you can have people take you for a cup of
33 coffee if your mental health - you know, there's a whole
34 series of support services that we provide for people
35 living in their home - travel in to Wagga for doctors'
36 appointments; whatever else; Meals on Wheels. So they're
37 all under that - they've all got different funding models
38 but they're all delivered out of the one door, one
39 interface.

40
41 MR GLOVER: This is a council-operated service?

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43 MR DONOGHUE: Correct.

44
45 MR GLOVER: Staffed by council employees?

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47 MR DONOGHUE: Yes.

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MR GLOVER: And you mentioned different funding models. What are the funding sources for that program?

MR DONOGHUE: Yeah, that's - I would probably prefer my accountant to come in to talk to you about that, because that's where we get very technical. The state government --

MR GLOVER: Given that there seem to be a number of funding sources being drawn on, it may assist the Commissioner if, some time over the next little while, you're able to provide us with a document that sets out the service and the funding flow.

MR DONOGHUE: All right.

MR GLOVER: Would you be prepared to do that?

MR DONOGHUE: Very happy to do that.

MR GLOVER: Would that make you more comfortable than me asking you some questions on the spot?

MR DONOGHUE: It would, to be honest, yes.

MR GLOVER: That would be very helpful.

MR DONOGHUE: I will say, if I can, may I?

MR GLOVER: Yes, please.

MR DONOGHUE: That space is a very difficult space if you are trying to seek help or support for your loved ones, your family, whoever needs it, and that confusion was under the different models, being all phone delivered, you know, you rang up and you got put through to someone. We consciously maintain that shopfront window and our community knows that, oh, mum's getting a bit old, or whatever, you knock on the door and they help you, as opposed to - it's a very disparate system if you don't know that, and a lot of people talk to us about, saying, "Oh, it's just so nice to go in and be led through the whole process."

I'm going to say in 2014 we had probably three packages. We've had to max out at 75. And that 75 max out

1 is not because people aren't coming to us, it's because we
2 don't, again, have the workforce to do it, which is, once
3 I get Allawah Lodge right, I now need to then turn my
4 attention to how do I staff the community care package
5 provisions, because more and more, people are living in
6 their homes, and you're getting them at Allawah Lodge, you
7 know, it's nearly palliative care, and we need to change
8 Allawah Lodge; we need to provide more palliative care
9 rooms in Allawah Lodge because that's the level that we're
10 getting. And I'm going to say, as a society, we've dropped
11 the ball on caring for our aged.

12
13 MR GLOVER: All of the services in the aged care space,
14 and including the community care services that the council
15 is providing - is that another example?

16
17 MR DONOGHUE: Yeah.

18
19 MR GLOVER: Is that, taken as a whole, the example of what
20 Councillor McCann was talking about, where the council is
21 stepping in because there isn't an equivalent service
22 within the region to care for your community?

23
24 MR DONOGHUE: I need to be a little bit careful with that
25 answer, because the simple answer is yes. What you've got
26 to be sort of conscious of is, we've created a market there
27 that people come through that door, because it's a better
28 system than the current other models that people struggle
29 to weave their path through, on what care they need. If
30 you ring up a care provider that only does - mows your
31 lawns because you can't mow the lawn, well, then, they're
32 not going to help you with Meals on Wheels and they're not
33 going to make - and what it creates in our community is
34 that the community care staff know everyone in that
35 community and what level they're up to. So when it comes
36 time to Allawah Lodge or to the retirement village -
37 everyone in the retirement village is on packages now
38 anyway, nearly - is that we've got that continuity of
39 knowledge of what is out there, so that we can plan that
40 future care needs.

41
42 MR GLOVER: Those community care staff can coordinate care
43 across a range of providers?

44
45 MR DONOGHUE: Yes.

46
47 MR GLOVER: And over a time continuum?

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MR DONOGHUE: We've had examples where the health system has come to us to help with someone in the hospital because we can manage that care needs across a broader spectrum.

MR GLOVER: All of what you've described in your evidence this morning in terms of the council's involvement in healthcare services might not be considered the traditional business of local government; would you agree?

MR DONOGHUE: I'll get Dave to speak to that because he's --

MR McCANN: No, as I said, roads, rates and rubbish, but no, it's certainly not. But as I've said before, if it's not done, it won't be done.

MR GLOVER: What can the system - that is, we'll start with the state health system for the moment. What can the state health system do to assist the council in meeting the needs of its community in this space?

MR McCANN: I think local government needs to have a seat at the table. We are very fortunate here that our relationship with Murrumbidgee local health is extremely good, and I have to emphasise that. We have a very good working relationship. I know that's not the case right across the state. There are areas of the state, particularly to the north, where there's perhaps conflict between local government and their local health districts.

MR GLOVER: Are you aware of that through discussions with your mayoral colleagues?

MR McCANN: Through discussions, yeah, at - particularly through Country Mayors Association. But speaking locally, we're very fortunate that we have a very, very strong working relationship, which is good, because we've been able to achieve a lot by working together. But if circumstances change, dare I say personalities change, that could change as well. It's not set in cement as far as a working relationship goes. So I think there's a place for local government at the table, at the high level in state government, and indeed, probably at the federal level, in some way, shape or form, so that the voices of local government can be expressed.

1 MR GLOVER: In a more formal way than exists presently; is
2 that what you have in mind?

3
4 MR McCANN: Yes, I believe, yes. I think - and I may be
5 speaking more for rural and regional councils than
6 metropolitan councils. Obviously in the metropolitan area,
7 there is no need, I think - I don't think for the councils
8 to be as involved as we are in the provisions of health
9 services. But certainly in rural and regional New South
10 Wales, it's crucial.

11
12 MR GLOVER: You mentioned in that answer that you have
13 quite a good working relationship with the local health
14 district here.

15
16 MR McCANN: Yes.

17
18 MR GLOVER: What works well about your interaction with
19 the district?

20
21 MR McCANN: We have a strong relationship with their
22 leadership team, so that, if I use the case in point of the
23 MPS that we're hoping to see constructed eventually in
24 Coolamon, or redeveloped in Coolamon, we've been able to
25 talk with their planning staff and their hospital staff to
26 come up with a services plan, which is very - it's quite
27 innovative, really. As I mentioned before, it's working on
28 the hub and spoke model, which integrates not only an MPS
29 at Coolamon with the base hospital at Wagga, but it also
30 future-plans for a push from particularly the local member
31 in Wagga, Dr Joe McGirr, who is keen to see regional doctor
32 and health professional training developed in Wagga.

33
34 So to have facilities, as we have, at Coolamon, will
35 assist that by allowing an opportunity for them to be
36 trained in aged care, in all of those different areas, in
37 Coolamon itself. So it's really about providing the
38 facilities around the central base hospital, which is
39 obviously in Wagga, to take the pressure off the base
40 hospital so that it can free up beds, and so forth, by
41 having the patients moved to smaller facilities like
42 Coolamon and Junee and also provide a training opportunity
43 for doctors in regional New South Wales.

44
45 MR GLOVER: So in that context, you feel that the
46 executive of the district and the council work well
47 together to pursue those aims?

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MR McCANN: I do, yes.

MR DONOGHUE: Can I just add to that?

THE COMMISSIONER: Yes.

MR DONOGHUE: Like, to the point where they know our strategic outlook and where we want to go, and we know theirs. We know they know our shortcomings on, you know, funding and where we need support, and we can help them. So I think we're about to apply for a business plan, for a whole of precinct strategic plan through the federal government that will support all of those users moving to a better model. So we're trying to help the health system in pushing for a better model that will provide better services than we have just discussed.

MR GLOVER: Has that good working relationship been developed through the personalities involved on both the council and the district side in your view?

MR McCANN: It's a difficult question to answer. Probably again, the short answer is yes, that the - I've found the Murrumbidgee health exec leadership team to be very receptive to councils and for the needs of rural communities and I think we can ask no more than that.

MR GLOVER: Mr Donoghue, earlier Councillor McCann indicated a view that there may be some benefit in having more formalised arrangements for local government to, I think he said, have a seat at the table. Do you have a view about that?

MR DONOGHUE: I think open discussions for rural and regional areas to provide lots of services where markets have failed - it doesn't just happen in the health system. So you asked, "Do normal councils do this?" Well, I'm going to say it's 15 per cent of my job. I still manage roads, I still manage tips and parks, and we do child care as well, because that's another, you know, market failure. We do it because we've got a very good team that are supportive. So the more we can provide that information, the better decisions are made. I'm not going to say we've got all the answers or know everything - we don't, we're just working within the confines that we have, and if both the federal and the state government know people on the

1 ground who can describe those shortcomings, then surely
2 there's better outcomes - is a possibility.

3
4 MR GLOVER: Councillor McCann, in an answer you gave,
5 perhaps right back at the start, you said that you felt
6 there should be greater recognition by the state and
7 Commonwealth governments of the role that local government
8 has in the delivery of healthcare services. You qualified
9 that by saying it doesn't necessarily mean money. Can you
10 just expand on what you had in mind?

11
12 MR McCANN: Well, again it probably goes back to my other
13 statement, to have a voice, a seat at the table, as I said,
14 to be able to - well, to be asked by the health system what
15 the needs of our community are, what we're providing, and
16 so that they can understand perhaps where they're failing.
17 So rather than us telling them, it's - you know, it becomes
18 a sort of them and us argument, that council comes along
19 and we're complaining because health services aren't being
20 provided.

21
22 We would simply ask that they understand what we're
23 saying, that we are providing health services, we're there
24 to help. We want to attract medical practitioners, we want
25 to attract staff. What can we do to help you? And we've
26 done these things that we've done in Coolamon off our own
27 bat over 30-odd years, longer, perhaps, and we've
28 achieved - I think our achievements are quite good.

29
30 We've established a health precinct with a hospital,
31 aged care - all of the things are within a stone's throw of
32 each other. That's not the same in other shires. Other
33 shires' hospitals are separate to their doctors and all of
34 these sorts of things, but NSW Health, if they can
35 understand that regional New South Wales is different to
36 metropolitan New South Wales and that the needs of country
37 people are the same, irrespective of where they live. So
38 we want to - I guess we want to be heard, is what I'm
39 saying.

40
41 MR GLOVER: Would that in your view --

42
43 MR DONOGHUE: Can I just --

44
45 MR GLOVER: Yes, of course you can.

46
47 MR DONOGHUE: You said, "Is it the personalities?" I'm

1 going to say there's a level of trust that has been
2 created. Now, trust is very hard to create. So I don't
3 want to say it's a personality, it's a trust level that
4 allows open discussion with the MLHD.

5
6 MR GLOVER: But do you see benefit for that type of open
7 discussion not just at LHD level but at state and perhaps
8 federal government level as well?

9
10 MR DONOGHUE: Yes. Yes, I do, but I want to put on the
11 back of people's minds that every circumstance is
12 different.

13
14 MR GLOVER: Quite.

15
16 MR DONOGHUE: Like, you'll ask us, "Well, why would you
17 put a doctor with a dentist?" Well, once you know why, it
18 makes sense. But that's --

19
20 MR GLOVER: What you're pointing to is tailoring local
21 solutions to local needs; correct?

22
23 MR DONOGHUE: Yes, that's a better way of saying it.

24
25 MR GLOVER: Is one of the benefits of that open
26 communication across all levels of government -
27 Commonwealth, state and local - the ability to better
28 coordinate and target resources, be they financial or
29 personnel?

30
31 MR DONOGHUE: Yes, because you're making solutions to care
32 for communities, depending on the communities' needs.

33
34 MR GLOVER: And perhaps an enhanced ability to have the
35 system as a whole, across each of the three levels of
36 government, work in the same direction.

37
38 MR DONOGHUE: I thought that was how we were supposed to
39 run our health and aged care systems, was holistically
40 through all three levels of government cooperating.

41
42 MR GLOVER: When you say that's how you thought it was
43 supposed to run, do you have a view about whether that's
44 being achieved at the moment?

45
46 MR DONOGHUE: We're trying our hardest in Coolamon to
47 deliver that. We have hurdles. I sort of understand where

1 some of those hurdles come from, but you would hope that
2 they could be tailored to each region's needs and outcomes
3 achieved.

4
5 MR GLOVER: The hurdles you have in mind in that answer,
6 are the ones you have raised in your evidence today or are
7 there others?

8
9 MR DONOGHUE: No, they're the hurdles, the funding
10 hurdles, the different levels of care, the acquittal
11 processes - in my mind, the ultimate outcome is, is the
12 person receiving the care they need, and that's what we
13 should focus on.

14
15 MR McCANN: Could I just say as well, Tony mentioned
16 Groworx before and our push to bring Filipino aged care
17 workers into Coolamon. That's another example, I think, of
18 local government doing something that local government
19 doesn't normally do. We're not, as a rule, immigration
20 agents, we don't chase overseas workers for council jobs,
21 ostensibly. But that's an area that Coolamon Shire has had
22 to lead in New South Wales, in fact, because we have found
23 that of the nine other councils that provide aged care, we
24 weren't alone. They were suffering as well. And so we,
25 through Tony's initiative, organised - connected with
26 Groworx.

27
28 Our initial plan was to bring nurses to our facility.
29 We found a roadblock because the qualified nurses that were
30 available through Groworx from the Philippines are trained
31 under the United States of America system, which is not
32 recognised in Australia. So we weren't able to bring them
33 to Australia as nurses, they were coming as aged care
34 workers, which they are now employed and doing a good job.

35
36 But what we will do now as a council is train those
37 nurses to Australian standards, and that will come at
38 a cost, I think, of 250,000, for council to find, to train
39 those up as nurses. The benefit of us doing that is (a) we
40 will have the right number of nurses we need to meet our
41 obligations under the Act; but in two or three years' time,
42 those nurses will be free of their obligation to Coolamon
43 Shire and be free to move into the New South Wales health
44 system if they so desire.

45
46 So to me, that's an example of local government
47 helping the state government by training nurses - again,

1 not a job that many councils would see they have to do.

2

3 MR DONOGHUE: I'm just going to add to that. Who would
4 have thought I had to know about 472s and 481s and all of
5 that? Well, I've had to learn all of that, and when those
6 nurses - sorry, those care staff, employees, have come out
7 here, some of them are wanting to bring their kids out, as
8 they would like to, when they come out here, we've
9 discovered that they have to pay full fare in the state's
10 education system. So that's 5,000 per kid. So we've got
11 to - you know, they're getting taxed 38 cents in every
12 dollar they make, they're now having to find 10 grand
13 a year for two kids to go to school.

14

15 MR McCANN: Public school.

16

17 MR DONOGHUE: Public school. So we're now advocating why
18 is that not a rural and regional incentive, that the
19 government says their kids can be for free? I accept that
20 if they land in Sydney, you know, there are so many options
21 in Sydney, but what encouragement can we have for those
22 immigrants to come out to the rural and regional areas? If
23 we could get their education sort of covered under our
24 health - our education system, would that not be a huge
25 incentive for rural and regional areas to get a workforce
26 that we just can't get at the moment?

27

28 So that's like a byproduct of the discussions we're
29 having over here, is now with our local member to talk to
30 the education department about whether that - because under
31 the PALM scheme, they do; under the 481, they don't. So it
32 seems a weird misconnection, again.

33

34 MR GLOVER: Another example of where communication between
35 local government and state government on an ongoing basis
36 may be able to overcome some of these issues as they arise;
37 correct?

38

39 THE COMMISSIONER: That's the Commonwealth Government,
40 isn't it, we're talking about?

41

42 MR GLOVER: No, well the state for the --

43

44 MR DONOGHUE: Immigration is the Commonwealth Government,
45 but I think the state fund the PALM scheme, regionally.

46

47 MR GLOVER: And the state would be the issue about the

1 school fees?
2
3 MR DONOGHUE: Correct.
4
5 MR GLOVER: Finally, Mr Donoghue, earlier in your evidence
6 you indicated that there are two GPs at the moment.
7
8 MR DONOGHUE: We currently have two.
9
10 MR GLOVER: Is that at the precinct?
11
12 MR DONOGHUE: Yep.
13
14 MR GLOVER: Are there any others in the shire, that you
15 know of?
16
17 MR DONOGHUE: No - well the third - the four I've
18 described are coming through that practice, so there's no
19 other - people drive in to Wagga, if they've got
20 a shortage, but locally in our shire council, there are two
21 currently in the practice, two pending.
22
23 MR GLOVER: Are the two currently in the practice they
24 sufficient to meet the needs of the community?
25
26 MR DONOGHUE: Well, under the - I don't know, the doctors,
27 whatever, allocation they do, it should be one doctor per
28 thousand head of population. We had one for 4,300, so four
29 is about where we should, on the guidelines. I'm sorry,
30 I don't know where those guidelines come from, but that's
31 the rule of thumb on doctor to resident.
32
33 MR GLOVER: Two at the moment, two pending?
34
35 MR DONOGHUE: Two at the moment, two pending. We only had
36 one until about two and a half years ago. So we're very
37 buoyant about moving to four, if possible.
38
39 MR GLOVER: Thank you, Commissioner.
40
41 THE COMMISSIONER: Just before you finish?
42
43 MR GLOVER: Yes.
44
45 THE COMMISSIONER: I know it hasn't been the practice so
46 far, perhaps I should have discussed this with you before,
47 but it's not that controversial. Mr Donoghue's witness

1 outline is reasonably detailed and it has some facts in it
2 that might make it easy to refer to. Is there a reason it
3 can't be tendered, to give it some formal status?
4

5 You can think about it later. We can do it at any
6 time. But it just seems to me the sort of statement that
7 you might tender for ease.
8

9 MR GLOVER: Yes, I just would need to be sure that
10 Mr Donoghue was in a position to adopt everything that's in
11 it. It's an outline rather than a statement. Perhaps,
12 Commissioner, we might take that up when Mr Donoghue
13 provides the additional information that he has kindly
14 offered to do.
15

16 THE COMMISSIONER: That might apply to some of the other
17 outlines, too. I mean, other people have gone, but I know
18 they're intentionally not drafted the way you draft
19 a statement for contested litigation but this one seems to
20 me, at least in the category, it would be helpful if it was
21 tendered.
22

23 MR GLOVER: We might take this, supplement it with the
24 additional information that Mr Donoghue has indicated will
25 come through and then we can tender it in that way, if
26 that's convenient.
27

28 THE COMMISSIONER: No drama, thanks. I think we'll just
29 proceed with the next witness. I'm sorry, do you have any
30 questions, Mr Chiu?
31

32 MR CHIU: I don't have any, but thank you, Commissioner
33

34 THE COMMISSIONER: You don't? See, I knew that, somehow.
35

36 Thank you very much to both of you for your time and
37 your evidence. We're very grateful. You are excused,
38 subject to what Mr Glover asked to be followed up with.
39

40 <THE WITNESSES WITHDREW
41

42 THE COMMISSIONER: We will proceed with the next witness.
43

44 DR WATERHOUSE: I call Professor Tara Mackenzie.
45
46
47

1 <TARA MACKENZIE, affirmed: [11.06am]
2
3 THE COMMISSIONER: Dr Waterhouse will ask you some
4 questions and Mr Chiu might as well after.
5
6 <EXAMINATION BY DR WATERHOUSE:
7
8 DR WATERHOUSE: Q. Could you please state your full name
9 for the record?
10 A. Professor Tara Mackenzie.
11
12 Q. And you are the associate dean of rural health for the
13 School of Clinical Medicine at the University of New South
14 Wales?
15 A. I am.
16
17 Q. Now, to be clear, that is the associate dean across
18 all of the UNSW rural clinical schools; is that correct?
19 A. That is correct.
20
21 Q. Not just Wagga. Wagga Wagga was, as I understand it,
22 the first rural clinical school?
23 A. It certainly was. In 2000 it started, with three
24 students at that time.
25
26 Q. How many, sorry?
27 A. Three students at that time.
28
29 Q. How many rural clinical schools are there now?
30 A. So in terms of our campuses we have five. We have one
31 at Coffs Harbour, Port Macquarie, Wagga, Albury and
32 Griffith, and across those campuses we have close to 300
33 students.
34
35 Q. We're actually going to bring up the document that has
36 been sent through with some of those details. This is
37 [UNS.0001.0002.0001]. Are you able to see that? I can
38 hand you --
39 A. Yes, I can. Thank you.
40
41 Q. There's a paper copy coming to you.
42 A. Thank you very much.
43
44 Q. Just looking at that, I calculated last night, there
45 are 282 students as at 2023, although that might have gone
46 up slightly. Is it the intention that the numbers will
47 increase or would you see the rural clinical schools as

1 being at capacity, what they have now?

2 A. At this stage, we have one more year to increase
3 because, as you recognised, Wagga, end-to-end training only
4 started four years ago, and so we still will, for the next
5 two years, be increasing slightly, and we expect our
6 capacity to be around that 300 as opposed to the 280 mark.

7

8 Q. I see there that for Wagga and Port - I take "Port" to
9 mean Port Macquarie?

10 A. Yes, thank you.

11

12 Q. So that has six years of trainees at each of those?

13 A. Correct. Correct.

14

15 Q. That's what you would mean by the end-to-end?

16 A. End-to-end training, correct, yes.

17

18 Q. Is that for all students in the program, they're all
19 doing end-to-end?

20 A. It is. So basically students can be in our local high
21 schools or anywhere they wish, they can do their full
22 six-year program, which is the identical program to what
23 they would receive in Kensington with the identical degree
24 at the end, but they can do all of their six years of
25 training at Port and Wagga.

26

27 Q. Can I ask why there are only four students in year 4
28 at Wagga?

29 A. So year 4 is a special research year. So each student
30 chooses a topic of interest for their research and that
31 year is a research year, which is how they have their MD at
32 the end of their degree. So some students choose to do
33 that research year in rural, some students choose to do
34 that research year in metro.

35

36 I am very proud to say we've tripled our numbers doing
37 their research year across our campuses. If I had shown
38 you those numbers for two years ago, there were hardly any
39 at all. So we are certainly building that group, but a lot
40 of our rural students may choose to go to Sydney for nine
41 months just for a particular research project, that might
42 be scientific, that's not available rurally, but they come
43 back to finish their fifth and sixth year.

44

45 Q. I might just pause for a moment to say that, for the
46 sake of the court reporters, you are speaking quite quickly

47 A. My apologies.

- 1
2 Q. So if you could just slow it down slightly --
3 A. I will, thank you.
4
5 Q. We can't afford to exhaust them before morning tea.
6 A. That sounds fair.
7
8 Q. With the Coffs Harbour and Albury students, they are
9 only from year 3 to year 6 --
10 A. Correct.
11
12 Q. -- is that right? Does that mean they do the first
13 two years in Sydney?
14 A. They can, or they can do their first two years in,
15 say, Port Macquarie, year 1 and 2, and then go to Coffs
16 Harbour, 3, 4, 5, 6, or same in Wagga to Albury. It's
17 a mixture at the moment, particularly in Wagga and Albury,
18 given we've only just started the end-to-end in Wagga four
19 years ago. So we probably have the majority of Coffs would
20 have done their first two years in Port, whereas in Wagga,
21 it's still probably a 50:50 mix, but I can see in a couple
22 of years' time, that will actually be very similar to what
23 it is up north.
24
25 Q. So is it the intent ultimately to make those two other
26 rural clinical schools a six-year program as well?
27 A. At this stage I don't believe that's the intention of
28 UNSW, but there's certainly nothing that excludes it. My
29 understanding is the only end-to-end training will be at
30 Port and at Wagga, feeding in to our other rural sites.
31
32 Q. It refers there to Griffith having short-term
33 placements. How long are those placements?
34 A. So these are four-week placements, and they are for
35 the metro students. So for our funding, our federal
36 funding, each local Australian citizen permanent resident
37 who is a student in Sydney needs to do a four-week rotation
38 to a rural site and we utilise our Griffith campus
39 primarily for those particular students, as we do our 70
40 primary care placements that we also have across the state.
41
42 Q. So it's not elective, it's mandatory?
43 A. It's mandatory.
44
45 Q. What year do they tend to go in?
46 A. They tend - we keep it to the senior years, so they
47 can get more out of, you know, interacting at the hospitals

1 with the patients. So I would say probably 95 per cent
2 would do it in their fifth year and the other 5 per cent
3 would do it in their sixth year.

4

5 Q. What sorts of experiences will they have at Wagga?

6 A. So - in Wagga?

7

8 Q. Sorry, I beg your pardon, in Griffith?

9 A. In Griffith?

10

11 Q. Yes.

12 A. So they are attached to a team. So they preference -
13 they can put in a preference as to what they would like to
14 do. It ranges from four weeks with a primary care GP
15 practice, obstetrics and gynaecology at the hospital,
16 surgical rotation at the hospital, internal medicine,
17 paediatrics, anaesthetics. So it really gives them a broad
18 view.

19

20 I know particularly, for example, the surgery rotation
21 is very popular with the students because it might be the
22 first time that they've ever been in a theatre actually up
23 close. Unlike metropolitan, where there might be layers
24 and layers of people between them and the patient and the
25 consultant, they're actually getting in there and holding
26 things and things like that. So I know that that's
27 a particularly popular rotation.

28

29 Q. Further down the page there, there are details of the
30 graduates of the rural campuses that are now practicing in
31 rural areas?

32 A. Correct.

33

34 Q. Does this include doctors at all stages of their
35 careers, so intern through to GP or specialist?

36 A. My understanding this data refers to people after the
37 first two years, so it doesn't count internship and PGY2
38 but it does count those after that, is my understanding.

39

40 Q. So it would count potentially some registrars that are
41 training towards general practice --

42 A. It would, correct.

43

44 Q. -- or specialty training? Where it says "Other rural
45 and regional area", does that mean that it could be - that
46 it's in the surrounding area for, say, Albury or Wagga
47 Wagga, or does it mean it's anywhere rurally?

- 1 A. Anywhere rurally.
2
3 Q. In Australia?
4 A. Anywhere rurally.
5
6 Q. So they may have moved to Victoria or something?
7 A. Correct. Particularly, for example, for Coffs, they
8 often go to Queensland, rural Queensland.
9
10 Q. Do you know what these figures represent in terms of
11 a percentage of the graduates of rural clinical school?
12 A. I am sorry, I don't.
13
14 Q. Are you able to comment on any of the 42 that are in
15 Wagga Wagga who you may have contact with through your
16 professional dealings?
17 A. Yes, so we have many general practitioners, and what
18 I will say is they're often not in - well, they might be in
19 Wagga but they're often in, if I can use, Gundagai and
20 Temora as examples. So in Gundagai we have two of our GPs
21 there, actually, sorry, three, who are alumni from the
22 Wagga Wagga clinical school campus and two of them are now
23 academics back in our Wagga campus teaching our now
24 students. Likewise in Temora we have - and Young and
25 a range of the smaller towns.
26
27 Most of them are GPs but we certainly do have some who
28 have completed other specialty training and have come back.
29 Psychiatry, for example, is one example, internal medicine,
30 surgery are a couple of others in Wagga.
31
32 DR WATERHOUSE: I might take that document down, now. We
33 don't need that further.
34
35 Q. I'd like to talk about the rural entry scheme. So
36 does this apply for all of the students that are at rural
37 clinical schools or only a subset of those students?
38 A. It applies for all of the students. Five years ago,
39 it didn't. But now it does. So there are 60 places each
40 year through the rural entry scheme for University of New
41 South Wales.
42
43 Q. And what are the criteria that are used to assess
44 whether a student will be accepted to the rural entry
45 scheme?
46 A. So we actually have four broad criteria that we use.
47 The first is the rurality, if I start with that one. So

1 that is the criteria that's set by the federal government
2 for all rural schools, and that is five consecutive years
3 living in an MMM2 and higher, or 10 cumulative years
4 similar, so that's the rurality part of it.

5
6 Q. Before you go further, can you just describe what MMM
7 means?

8 A. So it's the Modified Monash criteria, and my
9 understanding is 2 is Wagga, for example; 2 is Albury; 2 is
10 Port; and the smaller towns, the smaller the town the
11 higher the number.

12
13 Q. So can you give us an example in the district of
14 something that might be a 6 or 7?

15 A. So Broken Hill, I know it's not our district, but that
16 would be a 6, I would say.

17
18 Q. So that's the MMM criterion?

19 A. Correct.

20
21 Q. And I understand that there's a particular UNSW sort
22 of qualification of that rurality requirement?

23 A. That's the first part of it. It's not so much
24 a qualification, but once a student meets all of those four
25 criteria that are outlined, we then rank rurality higher.

26
27 So, for example, if you have a student who has been in
28 Finley High School and done their 12 years of school in
29 Finley, one of our smaller towns, they would be ranked
30 higher than someone who had been in a boarding school in
31 Sydney for six years, even though they might have been born
32 in Finley, if I can just use that as an example.

33
34 So it's not so much the criteria to get on to the list
35 to be accepted, it's where they sit on the list is put into
36 that equation so that we're truly, you know, representing
37 the rural communities to the best that we can and
38 highlighting that.

39
40 Q. Thank you. And the other criteria, maybe if we can go
41 through those?

42 A. So the second criteria is something called the ATAR,
43 which I'm sure everybody in the room is familiar with, and
44 essentially if you were a metro student with UNSW, the
45 average ATAR is about 99.85. Our medicine degree for UNSW
46 is actually the highest ranked university degree of any
47 kind nationally. For the rural entry scheme, instead of

1 that, it's 91. So it lowers the ATAR as the criteria.
2 There are no mandated topics to cover at school, so we
3 don't look at what they do at school; it's just the ATAR
4 itself. So that's the second part.

5
6 The third part is the UCAT. A UCAT is a test that is
7 done basically to look at a range of areas of situational
8 judgment, professionalism, and they have to be in the top
9 50 per cent of the state to actually be eligible to enter
10 medicine.

11
12 Q. If I can just qualify that, what does UCAT stand for?

13 A. University criteria admission - I don't know what the
14 "T" is --

15
16 THE COMMISSIONER: University clinical aptitude test.

17
18 THE WITNESS: Thank you.

19
20 THE COMMISSIONER: But I'm just reading it.

21
22 THE WITNESS: Thank you very much.

23
24 DR WATERHOUSE: Q. So that is specifically for people
25 applying for clinical courses at university; is that
26 correct?

27 A. Yes.

28
29 Q. You said that it was the top 50 per cent?

30 A. Top 50 per cent. Mmm-hmm.

31
32 Q. How does that compare with the mainstream UNSW course?

33 A. It's the same, although when you look at the
34 applicants and what they need to get, because it's so
35 competitive in metro, the number would be higher, but the
36 criteria is the same.

37
38 Q. So that's the rurality, the ATAR, the UCAT?

39 A. And the UCAT. And the fourth is the interview. So
40 this is an interview that's conducted in person, now that
41 COVID allows us to, with two community members. So, for
42 example, members of our Wagga local council are
43 interviewers; members of our community who are - because
44 when I say "community", I mean community, I don't mean
45 medical community, and so other members of our community,
46 as well as a member of the medical community, so there's
47 one of each.

1
2 There's an interview that lasts for about half an hour
3 to 45 minutes for each student, with set questions. So
4 every student is asked the same question, whether they're
5 interviewing in Wagga or Albury or wherever they happen to
6 interview, and then they are rated at the end of that
7 interview as to how suitable they are to be a doctor and
8 how suitable they are, because it's rural, to be a rural
9 doctor.

10
11 Q. What sorts of questions might be considered - might be
12 included?

13 A. So, for example, we might ask them about their - an
14 example of engagement with their local community in a
15 charity group or a sporting group; we may ask them around
16 an example of something they've taken away that they've
17 learnt at school, they've applied in their local community.

18
19 One section of the interview is just on the rural
20 questions and then the other sections are identical for the
21 metro and the rural students, because it's - everybody gets
22 an interview, whether they're metro or rural.

23
24 Q. To get into medicine?

25 A. But the actual questions are actually confidential, so
26 I can't actually go through them in detail.

27
28 Q. Yes, that's fine. Is the scheme aimed only at
29 school-leavers or can anyone, a mature aged student, say,
30 apply?

31 A. The vast majority are undergraduate from
32 school-leavers. We do have two other processes that are
33 rarely used, something called a lateral entry scheme, so
34 that is where students do the University of New South Wales
35 biomedical science degree, and if they get a certain mark,
36 and I'm not sure what it is, but a certain mark in the
37 first two years of that degree, they can transition
38 straight into medicine, and they could choose to do that in
39 Wagga or Port Macquarie, for example, for the first year.
40 That's lateral entry.

41
42 We probably - I don't know the exact numbers but it
43 would be a handful each year that would - certainly fewer
44 than five. Very rarely, we will have postgraduate entry
45 but they start at the beginning and so because there are
46 other rural postgraduate - like, Notre Dame, for example,
47 which is in Wagga, most students would choose to use

1 a postgraduate course to enter through postgraduate means.

2

3 Q. I understood from what you said before that these
4 students, will do their whole degree in a rural area?

5 A. Correct.

6

7 Q. Are there any sorts of benefits to them in terms of
8 sort of scholarship funds or anything of that nature that
9 come with being part of the scheme or is it just entry to
10 the university?

11 A. So from that entry - is just the entry, there's no
12 links to that. Separately, there are some scholarships
13 that are available through - some are through the
14 university, and they are both for metro and for rural, so
15 they're not dedicated rural. But what we have done, for
16 example, with the Wagga local city council, we've developed
17 some scholarships for our first-year students, that the
18 Wagga council very kindly have donated money to.

19

20 We also, very importantly, subsidise heavily the
21 accommodation for the first years, because one of the key
22 issues for us is actually accommodation for our students
23 that's affordable, and so we subsidise that heavily so that
24 they're paying the equivalent of what they would pay in a
25 college at UNSW in Kensington, not the 800 or \$900 a week
26 it might be in Wagga.

27

28 Q. I do want to move on to talking about the medical
29 program, but before I do that, I understand that you also
30 visit high schools to talk to them about studying medicine.
31 Can you give us an outline of what that involves?

32 A. Absolutely. So it's something that we developed when
33 I first started in this role three years ago. I've been in
34 Wagga a long time, but just started in this role three
35 years ago, and I am a big believer that we need to capture
36 our students early and make them believe that they can do
37 medicine.

38

39 So we have - I call it a "choose your own adventure"
40 model, where there's five different components and the
41 careers advisers and students can choose whatever component
42 is fit for their needs. So it starts with simple things
43 such as an information evening that we hold every year in
44 each of our sites, where any interested parents, students,
45 careers advisers can come and learn about the program in
46 detail.

47

1 I certainly do go and visit high schools and not just
2 in Wagga, I've been out to Hillston, for example - Hillston
3 is about three and a half hours away - where I met with
4 a group of 10 students anywhere from year 7 to 12. They
5 made the comment that it was the first time a university
6 had actually gone out in person to them, so I've been
7 there.

8
9 I've been to a range of different schools to talk
10 about the program. Generally that's through the careers
11 advisers. I write a letter to every principal and careers
12 adviser at the beginning of every year outlining the
13 options and then each school will take it up. So if I use
14 Wagga high school as an example, it takes it up every year
15 because it's a bigger school, it has students every year.
16 Whereas when I spoke to - I keep saying "Finley", but -
17 Finley, recently, that was the first time in five years
18 they had had a student who might have been interested in
19 medicine. So that part, the visits, vary. They can be in
20 person, they can be via Zoom, that's completely up to the
21 careers adviser. But I will go, because I think it's
22 really important that that child sitting in Finley knows
23 that they're just as important as somebody who's sitting in
24 Sydney. So that's the second part.

25
26 The third part is a skills session that we've set up.
27 So this is specifically for year 9 and 10 students, who are
28 identified by their careers advisers, or science teachers,
29 often, to have an interest, and they get a special
30 invitation to come to a bespoke session that we run on
31 campus, with their parents, where they learn how to use an
32 EpiPen, they learn how to use a stethoscope, they play with
33 the mannequins with our academic staff, of course, you
34 know, teaching them.

35
36 And the reason we get the parents is they get to see
37 the children doing it, and the parents start to believe
38 that the children can do it. So that's a really popular
39 part of what we do. We run it on a weekday evening for the
40 Wagga schools and a weekend morning for the out of town
41 schools, to allow travel.

42
43 Then the other part that we run is actually work
44 experience. So up until I started in my role, there was no
45 work experience - and I don't mean work experience with
46 a doctor, I mean work experience with a first-year medical
47 student. Because many of these students might be first to

1 university or first to medicine, and so they don't even
2 know what they don't know, and so they literally pair up
3 with a first-year student for a week. So if they're doing
4 a prac, they go to the prac. If they're doing a lecture,
5 they go to the lecture. If they're doing a clinical
6 session with a patient, they go to that clinical session.
7 And again, that has been very, very popular, and that's
8 something that we've run out of Wagga as well.

9
10 So they're sort of the different parts. Different
11 schools will choose different parts every year; other
12 schools will choose parts some years.

13
14 The last thing I will say in answer to your question
15 is, last year we ran a day where we had 98 high school
16 students, from year 10 and 11 primarily, come to Wagga from
17 all over the region, including Hay down, to have a day
18 where we had a thing for our allied health programs, metro
19 programs, as well as our rural program.

20
21 For example, the Gundagai paramedics found me
22 a crashed car, brought the crashed car to the car park with
23 an ambulance, and sort of learned how to - you know, a road
24 trauma which for us, of course, is an important part of
25 medicine. And again, just seeing the kids say, "I actually
26 can do this", that was - we had more students here than we
27 had at the metropolitan one of the equivalent thing they
28 ran, so I was very proud, because community is our strength
29 and I try to use that.

30
31 Q. Thank you, that's a very detailed assessment and
32 I won't go through all of it, but where you say that it's
33 very popular, apart from the 98 students that came to that
34 last one, how many students, for example, get involved in
35 following a first year medical student?

36 A. As many as want to. So there's no limit on that.
37 So - but I would say on average we would probably have 10
38 to 15 a year, but we've not turned anyone away because they
39 couldn't do it. That bit varies.

40
41 Q. On average how many do you have at the skills sessions
42 you mention?

43 A. We have six to eight students per session and we keep
44 it small so they can get more attention and we last year -
45 I'm very sure we ran either four or five. It was in that
46 vicinity, the numbers.

47

1 Q. Are you finding that there are high school students
2 who, a light goes on, almost, that they are able to do
3 this, where it was not something they had necessarily
4 foreseen as being an option for them?

5 A. Absolutely do. And in fact, one of those is my
6 medical student now in year 1. But yes, you see it. You
7 can see it, and you can see it in the parents' eyes too,
8 for the ones where they're there too. But no, absolutely.

9

10 DR WATERHOUSE: Commissioner, that might be a good time to
11 break before I move on to a new topic.

12

13 THE COMMISSIONER: Okay. We will adjourn until 11.50.

14

15 **SHORT ADJOURNMENT**

16

17 THE COMMISSIONER: Yes, please, continue Dr Waterhouse.

18

19 DR WATERHOUSE: Q. We had finished up talking about the
20 high school students program of trying to get them
21 interested in studying medicine. Can I get you to outline
22 what the medical program structure is, so what happens in
23 year 1, year 2 and so on?

24 A. So it is a six-year program, each program is divided
25 into phases, and each phase is two years. So in the first
26 year, the predominant is based at the campus, where they'll
27 learn the basic sciences, anatomy, physiology, chemistry,
28 those sorts of things. But even in year 1, they will have
29 one session a week with a patient, where it's led with
30 a tutor, of course. And so we really bring the patient
31 into the program in year 1.

32

33 Year 2 is very similar to year 1, building on the
34 basic sciences, with the addition of an extra session of
35 clinical. So they get two half days.

36

37 Q. And before we go on from there, when you're talking
38 about "clinical", what are they doing with those patients?
39 They're not able to make diagnoses in year 1 or 2, so --

40 A. They learn how to take a history, they learn how to
41 examine and patient, and really that's what they learn in
42 those first two years.

43

44 Q. And then moving on to year 3?

45 A. So year 3 is about a 60:40 mix, with about 60 per cent
46 based at the hospital or primary care practice now, and
47 40 per cent being based in the campus, and it becomes now

1 much more around clinical areas - so, for example, aged
2 care, oncology, primary care. So that's year 3. And they
3 do start to make diagnoses, do a lot more with the
4 patients, and it's the first time they would also see
5 a patient without a tutor with them. So they may go and
6 talk to a patient on a hospital ward separate to having
7 a tutor with them. That's year 3.

8
9 Q. If I can just stop you there, in terms of what they're
10 doing in year 3 with the rotations, are they sort of set
11 rotations - everyone will do geriatrics, everyone will do
12 oncology, et cetera?

13 A. They are set rotations but they are based - set
14 rotations, so that in the 12 months every student will do
15 the same thing but obviously at different times within the
16 year, and the rotation lengths are different depending on
17 the particular part that they're doing but the average
18 would be about eight weeks per rotation, mixed in with the
19 campus and the clinical placement.

20
21 Q. Year 4?

22 A. So year 4 is the research year that I outlined before.
23 So that's the first nine months of the year, but then
24 they - so even if a student had chosen to do a research
25 year, say, in Sydney, they would come back to the rural
26 campus to do the last three months, which is what we call
27 a clinical training course. So it's really setting them
28 back up for the last two years, which are all clinical, and
29 it's because they've just been doing research for nine
30 months, so to bring them back into the clinical. So it's
31 really a revision of what they've done in year 3 and
32 starting to build on that into year 5 and 6.

33
34 Q. What about the types of research that they do? Does
35 it tend to be basic sciences research or clinical research?

36 A. It's very varied. So certainly there are some who do
37 basic science research. For example, one of my students in
38 Wagga did their project last year in Wagga and they did it
39 in weight loss surgery, for example, and the benefits of
40 that to patients in the community.

41
42 We have students choosing AI as an area that they're
43 doing some of their projects in. So really, the way it
44 works is any clinician or academic can say, "I have
45 a project that might be interesting for a student", the
46 students get that list and then they choose what they want
47 to do within that project. But the list is endless in a

- 1 wide variety of areas.
2
- 3 Q. But they're choosing a project that someone else will
4 be overseeing with them --
5 A. Correct.
6
- 7 Q. -- for that participation?
8 A. Correct. They'll have two supervisors for their
9 project.
10
- 11 Q. Now, years 5 and 6, those are primarily in clinical
12 settings; is that right?
13 A. That is correct.
14
- 15 Q. Do they choose the setting or are they allocated to
16 settings?
17 A. There's a mixture. So they all do, for example,
18 internal medicine, surgery, obstetrics, paediatrics,
19 psychiatry. They also have a term called an elective term
20 and that literally is where they can choose to do anything.
21 The majority - because of COVID, the majority of students
22 will do that somewhere in Australia, but prior to COVID,
23 they used to, for example, go overseas sometimes to do that
24 elective, as an eight-week block. Then they'll also do all
25 their critical care rotations in that time, so intensive
26 care, emergency, anaesthetics, those sorts of things, and
27 each of the blocks is eight weeks.
28
- 29 Q. Can you just explain for the Inquiry what "internal
30 medicine" means?
31 A. So internal medicine is what I do, so it is a medical
32 specialty that - through the college of physicians, and it
33 includes things like general medicine, cardiology,
34 respiratory, which is what I do, and we have 20 physicians
35 in Wagga, for example. We're all sub-specialists, like
36 myself, but we all practice in general medicine through the
37 hospital, so it's a mix of both.
38
- 39 Q. Do they do paediatrics?
40 A. They do.
41
- 42 Q. So as I understand it, they can do year 5 and 6 in a
43 mixture of hospital settings and primary care settings?
44 A. Correct.
45
- 46 Q. Is that right?
47 A. That's correct.

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Q. What sort of primary care settings are they involved in?

A. So they do eight weeks of primary care unless they choose to do more in their elective, for example, and within that eight weeks we usually try to have them do four weeks in a regional town like Wagga, Albury, Port, and four weeks in one of our rural towns, such as Temora, Gundagai, Cootamundra, Narrandera, places like that.

Q. What would you see as the key differences between what you've outlined in the six-year program and what a student at Kensington would be doing?

A. I think the key - I think the two key differences are that the academics and clinicians know our students. We are invested in them as, you know, future colleagues, and so hence we can actually help develop their careers and their knowledge, because we're more invested, smaller group size, know how they're going.

I think the second big difference is the patients. The patients love having medical students. There's never a situation where you have to fight to actually go and see a patient. Whereas I can speak from experience, in Sydney, because there are so many students in a particular hospital, it's very common for patients not to want to see any more students, or it's common for a doctor to not know the students attached to them because they hardly see them. That would never happen rurally, because on paper, the curriculum is identical - so on paper, there is no difference - but in reality, I believe there is a big difference, and that is definitely reflected in the end of course marks.

Q. Now, what level of interest is there amongst clinicians in being involved in teaching medical students? You said that they know the students but is there a high level of interest in people want to go get involved in the rural clinical school?

A. Very much so, and that's both in fractional paid academic positions - for example, one of our GPs in Wagga, for example, is our lead in primary care, so has a paid position; one of our GPs in Gundagai is our skills coordinator, so they have a paid position. But in terms of conjoints, who are clinicians who put up their hands, from interns - so first year doctors up - I have 287 of them.

1 Q. So "conjoint academic", is that the term?

2 A. That's the term.

3

4 Q. That's somebody who is --

5 A. A clinician of some type.

6

7 Q. A clinician, but they're also doing --

8 A. Teaching, correct.

9

10 Q. -- teaching at the same time? And you've got GPs as
11 well as specialists involved in this. Do you have the full
12 range of specialties?

13 A. The only specialties we do not cover would be
14 cardiothoracic surgery and neurosurgery, because obviously
15 no rural place would. But we actually do cover all of the
16 subspecialties in internal medicine, in surgery and in
17 critical care. So literally about the only things they
18 wouldn't have exposure to are those very niche areas of
19 surgery.

20

21 Q. So taking the neurosurgery/cardiothoracic surgery, as
22 an example, how do students in the rural clinical schools
23 learn about those types of specialties?

24 A. In two ways. Firstly, there would be teaching from
25 Kensington that is fed back via, you know, Zoom or Teams or
26 something along those lines.

27

28 The other thing to say is that those particular niche
29 areas often are not needed for students. They need their
30 general surgery, they need their general skills, and then
31 they would build on those as doctors. So they certainly
32 do have tutorials, cases, that come from Sydney, but
33 generally - they also attend, for example,
34 multidisciplinary team meetings, so that's where surgeons
35 from Sydney would be zooming in to discuss the same cases
36 in Wagga, which we do once a fortnight. They get the
37 exposure that way as well.

38

39 Q. Is there any reason for the students to have to go to
40 Kensington during the six-year time?

41 A. Not unless they choose to.

42

43 Q. Not for wet lab type work or anything??

44 A. Sorry, I'll rephrase that. Port Macquarie definitely
45 don't need to because Port Macquarie have their own wet
46 lab. For Wagga at the moment because we don't have our new
47 building, they go once a term, a term being three months,

1 to Sydney for the wet lab, and the other labs are used at
2 Albury, there's a wet lab at Albury that we use.

3
4 Q. Can you just clarify the term "wet lab"?

5 A. I'm so sorry.

6
7 Q. That's okay, I started it.

8 A. So a wet lab is for cadaver specimens for anatomy
9 training. Most anatomy training these days is done without
10 cadavers but there is some that meet that, and that's the
11 wet lab.

12
13 Q. How many primary care placements are there in the
14 Murrumbidgee Local Health District?

15 A. I'm sorry, I don't know the exact number in
16 Murrumbidgee. It's 70 for our rural clinical schools
17 across the state for UNSW. But off the top of my head,
18 I would estimate at least 10 to 15.

19
20 Q. Apart from general practice, what other types of
21 primary health settings do they have?

22 A. So they would have experience in, for example, a drug
23 and alcohol unit, is one example; they may spend some time
24 in their rehab rotation, say, in a rehab component of the
25 clinical area. They also occasionally spend a bit of time
26 with a pharmacy, for example, and learn a little bit of the
27 pharmacy. So we try to utilise some of the other non-GP -
28 and then, of course, they would also have the specialty
29 rooms, clinical exposure, as well.

30
31 Q. Do you find with GPs in rural areas being somewhat
32 stretched, that there is any resistance to taking students?

33 A. Not - I wouldn't use the word "resistance", but very
34 sad they can't, at times, is how I would put it, because
35 I genuinely have never come across a doctor who doesn't
36 want to teach, but there are certainly some that can't
37 because of the reasons that you're outlining.

38
39 Q. Is there any competition between medical schools for
40 primary health placements?

41 A. There is potentially. We have tried to mitigate that
42 by having a head of school meeting once every three months,
43 where we have a common spreadsheet, to cut a long story
44 short, so we put all the rotations in so that any new place
45 doesn't clash with ones that are there. We have not
46 reached capacity yet, but we are close, and it is
47 potentially possible in the next few years that we may have

1 that situation.

2

3 Q. Are there any particular gaps in terms of the primary
4 health placements that can be offered, either in
5 geographically or the type of placement?

6 A. So there certainly are some gaps that are already
7 being utilised by, for example, Charles Sturt University
8 who are the more - the newer university in our region.
9 They are certainly using some of those practices, but
10 often, we are already - because we've been here since 2000,
11 we're already using a lot of the GP practices around.

12

13 Q. You mentioned before that students are sometimes going
14 to very small towns.

15 A. Yes.

16

17 Q. What sort of supports are in place to help them manage
18 their time there?

19 A. So we - well, firstly, there's financial support, so
20 we cover all their costs. The second thing is they will
21 have a supervisor, so they only go to these smaller towns
22 if we know there's a conjoint or a paid academic of ours
23 who is there.

24

25 They have a session at least once a week, and
26 sometimes more, where they will have teaching back at
27 Wagga, for example, if I use Wagga, so they will have that
28 link as well. We also have an administration person who
29 liaises with them very regularly, at least three or four
30 times a week, to see how they are going. And I will say
31 that often our small town rotations are the most popular of
32 the lot because of the community feel that they have when
33 they're there.

34

35 Q. So having got through the six-year course, the medical
36 student is now a postgraduate doctor, can they do those
37 initial postgraduate years in a rural setting?

38 A. So they can certainly do their first two years
39 postgraduate in a rural setting, and then it depends what
40 they choose to do as to whether they can do the rest of
41 their training. The single employer model, for example, is
42 a good --

43

44 Q. I might to come back to that, if that's okay. Let's
45 just talk about training, though, as a specialist. Is
46 there any limit on the amount of time for training, say,
47 with the college of physicians, surgeons, et cetera?

- 1 A. There definitely is. Every college except psychiatry
2 and except general practice have limits.
3
- 4 Q. Sorry, every college except --
5 A. Psychiatry and general practice?
6
- 7 Q. Has what limits?
8 A. Has a limit that there's a minimum - sorry, a maximum
9 time that you can spend rurally. So if I use respiratory
10 as an example, because that's what I've done, I would have
11 loved to have done all six years. I could only do one - so
12 I could do basically 18 months of my six years rurally and
13 everything else had to be done in the city.
14
- 15 Q. So to be clear, this is a position of the colleges?
16 A. Colleges.
17
- 18 Q. It's not the number of training positions on offer by
19 the districts?
20 A. That is correct.
21
- 22 Q. What, in your view, would be necessary to change the
23 perspective of the colleges in terms of those limitations?
24 A. I think, again I can only speak for my college,
25 because it's the only one I'm familiar with, but I would
26 extrapolate it to others, and that is that they need to
27 recognise that you can now do the majority of your
28 training - not 100 per cent but the majority of your
29 training - rurally and have the mind set where I might be
30 based rural but go back for 12 months to do the particular
31 niche area that I might need to bring back, for example.
32
- 33 But at the moment, my college has a minimum time
34 I have to spend in somewhere like RPA - that's where I did
35 my training - but there's a maximum time I can spend in a
36 rural, and to me, that should be the other way around.
37
- 38 Q. Is a part of the issue concerning that there are not
39 enough college fellows in the rural areas to oversee
40 training and provide training?
41 A. I think that is true for the smaller rural settings,
42 yes. Somewhere like Wagga, we have 20 sub-specialists in
43 medicine, so I think it's really changed a lot, and if you
44 look at Wagga, we have 20 subspecialist physicians, 17 of
45 us were trainees here, and that is our only link, and
46 I think that's a really good example, that if you can see
47 that career mentorship, it actually can work.

1
2 Q. Now, you mentioned before about the single employer
3 model. Can you give us a bit of an outline of your
4 understanding of that model?

5 A. So that model was a collaboration between the
6 University of New South Wales hub and the LHD, designed to
7 try and allow anyone who wanted to be a rural/regional GP
8 to do that training in a setting that was supported, had
9 appropriate supervision, and was able to overcome the
10 industrial issues that could be associated with those
11 roles.

12
13 So my understanding is that they do their internship
14 and then they can choose to enrol in this five-year
15 program. They can choose to be based in Wagga, for
16 example, and they can come out at the end of that five
17 years with a mixture of rotations with a GP practice, and
18 they would have a mentor at that GP practice; rotations in
19 the hospital, to get the areas that they need; and, most
20 importantly, their 12-month advanced skill year, where they
21 choose, anaesthetics or emergency or mental health or aged
22 care.

23
24 In the past, the registrars would have to fight very
25 hard because they would be fighting against psychiatry
26 registrar for the mental health year, for example. This
27 now allows them to have that dedicated year and be able to
28 train without having to fight for those positions.

29
30 Q. So do you mean that it's actually created additional
31 training positions?

32 A. Correct.

33
34 Q. For those advanced skills?

35 A. Correct.

36
37 Q. To be clear, is this for rural generalists?

38 A. It's for general practitioners. So this is
39 specifically for GPs who want to come out at the end of
40 that five years. The rural generalist is a similar type of
41 program but the single employer model is specifically for
42 rural GPs.

43
44 Q. Do you believe that there would be opportunities for
45 this to be - the single employer model to be expanded into
46 other fields?

47 A. Definitely.

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Q. What sorts of fields would it lend itself to?

A. I think it lends itself more to the either general fields, like general internal medicine, general surgery, for example, or some of the sub-specialty areas where you don't need to work in a very niche area to be that sub-specialist, which is, for example, upper GI surgery, is all run here, they don't need to go to Sydney; respiratory medicine, it's all run here, don't need to go. So things that are more general in nature, I think it definitely lends itself to.

Q. Has there been discussion with colleges, do you know, to try to explore those opportunities?

A. I do know - well, psychiatry there definitely was because now you can. I can't tell you exactly how long that's been the case but I know it's fairly recent. I know for the college of surgeons they have had discussions around entry, I'm not sure they've had the discussions around the program you're referring to, but I think my - if I can say with my college, there are so many different layers in the college and so many groups that control different things, it's hard to get them all in the same room to say how are we actually going to solve this problem.

Q. When you say there have been discussions around entry with the college of surgeons can you expand on that?

A. So if I can give the example that entry into the college of surgeons is very competitive, as you can imagine, and they have made a new rule now that being a rural JMO, so intern/resident and having been a student as well, is the equivalent to a PhD, and that's a really big deal. So in other words, I don't have to go off for three or four years and do my PhD to try to get into surgery. If I've done my medical school in Wagga, and I've been an intern and a resident in a Wagga, that's equal points to a PhD when you're getting the points to get into the college of surgery. So that's just a simple example of something that makes a tangible difference immediately.

Q. So that's only if you've done the whole of your training here --

A. That's my understanding.

Q. -- and your post graduate --

A. That's my understanding, yeah.

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Q. I understand that you are a respiratory position, as you mentioned, in Wagga. What's the nature of your practice?

A. So I am a visiting medical officer to the Wagga Base Hospital, and also to Calvary Hospital, and then I am based in my rooms, which is the Riverina Respiratory & Sleep Centre.

Q. How long have you practised in Wagga?

A. Since 2007, so about 17 years.

Q. Did you grow up in a rural area?

A. No. I'm a city girl.

Q. So what made you move to Wagga to set up a practice here?

A. Literally my experience as a doctor trainee. I went through medicine before rural clinical school so I didn't have that opportunity, but I did have the opportunity to come to Wagga as a registrar back in 2000, fell in love with the place, came back again in 2004 and did the first rural fellow year in the country, knew that I loved it. Went back to RPA, because there was a particular education role I wanted to fulfil, and then I've been back here ever since.

Q. And what do you enjoy in particular about being a specialist doctor in Wagga Wagga?

A. I enjoy the ability to make - and it sounds trite but an ability to make a difference and it's to be able to see the difference that you make. So I love my patients, I love my community, I obviously love my students, and I love the fact that I know every day, no matter what I'm doing, university, or clinical, I'm making a difference, and I'm supported by an amazing community. So to me, that's what's made me come and stay.

Q. So no job is perfect?

A. Correct.

Q. Do you have challenges?

A. Workload, yeah, absolutely. Waiting lists for patients. Again, to give you an example, I see probably 100 to 120 patients in rooms a week and I have waiting lists of over 12 months, and now obviously we triage referrals, but that's the key problem, is there is not

1 enough of us.

2

3 Q. Are you the only respiratory?

4 A. I'm one of four and there are still not enough of us.

5

6 Q. It has been said that specialists in metropolitan
7 hospitals actively discourage junior doctors, both from
8 training as GPs and from moving to rural areas. Is that
9 something that you have observed or are aware of?

10 A. I've experienced. So when I left RPA to come to Wagga
11 in 2007 - I'll put on record, I genuinely do love RPA and
12 loved my time there - I was told I was throwing my career
13 away when I came to Wagga and nothing could be further from
14 the truth.

15

16 Q. So what do you think can be done about changing that
17 mind set at a metro level?

18 A. I think it's showing them what you can do rurally.
19 So, for example, for myself when I came to Wagga, I showed
20 my colleagues at RPA all the amazing things we could do.
21 I think also having a pathway and a mentorship ability so
22 that people who are training in the city, metropolitan, can
23 see that they can have the choice, and then that, I think -
24 can I change a 70-year-old grey-haired professor's mind?
25 Probably not. But can I change the new generation coming
26 through? I would hope that I could.

27

28 THE COMMISSIONER: Q. Can I ask, when you were told you
29 were throwing your career away, Dr Waterhouse put really
30 two different things - one discouraging people from
31 training as GPs, and one moving to rural areas, which could
32 be separate. It was moving to a rural area that was --

33 A. Correct.

34

35 Q. -- what you were discouraged from?

36 A. Correct, yes.

37

38 DR WATERHOUSE: Q. What about the flip-side of training
39 in general practice; is that something you've seen?

40 A. I think that is something I certainly have seen -
41 metro not rural - but I've also seen change for the better
42 in our local area because of the ability and the mentorship
43 to see the GP in Gundagai, who is my medical student who's
44 now my academic, who is in Gundagai, two others have
45 followed her, for example. So it's the ability to see the
46 pathway, not in theory but in reality, I think, that makes
47 the difference.

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Q. Do you consider that networking with metropolitan colleagues is important for specialists in rural and regional areas?

A. It is critical.

Q. So how effective is that, in your experience?

A. I think it's variable. I'm proud to say in Wagga, I think it works very well. The MDT meeting, the multidisciplinary one I mentioned before, once a fortnight, every lung cancer patient in our region is discussed and the only people who we need to network with from Sydney are the cardiothoracics and they network in. We have other areas where we can network. I know many specialties do that with their metro colleagues. It is important.

You also have to be able to pick up the phone. If you see a patient, particularly early in your career, you're not sure what's happening, you need to be able to network to pick up the phone to help. So there's formal networking that's important, but there's also the informal networking as well.

Q. So for a doctor who has trained entirely in a rural area and doesn't have those metropolitan networks or colleagues, how can they work through that to develop the support system?

A. It's a good question. I think for specialists, I think you're going to be doing some of your training in metro even if, you know, it's the other way around to what it is now, so you'd have those networks. I think for rural people it's probably using their mentors' networks and having some way to link in to those.

The one good thing that came out of COVID, I think, is we are so used to Teams and Zooms and things like that, so there's a lot more networking happening often because you don't have to physically all go to one place in a state once a year. So I - it's a long answer to your question, sorry, but I think it really is the idea of utilising new tools to be able to help mentor and use your mentors' networks to start.

Q. Do you think there's a place for either people in remote towns to come to Wagga to do some upskilling or refresher training?

A. Definitely.

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Q. And likewise, people to come from rural and regional areas to the city to do that?

A. Absolutely.

Q. Should that be something that is formalised?

A. Formalised for areas where it's fit for purpose. So there'll be some where you genuinely don't need to do that, but the majority where you would at some stage, I think. Formalising it makes it a lot easier because you're not relying on "Phone a friend."

Q. Is that something that the state should look at, perhaps, enhancing the networking and refresher training options?

A. Yes.

Q. What else could the state do to try and improve the sort of strengthening of the bonds between rural and metro?

A. Well, I think it already has. For example, if I use the HETI model, so Health Education and Training Institute, they have networked many training programs, and so those networks, once they're in the training programs, are then keeping as networks once people have finished, and they have regular meetings amongst that. So it's developing the idea of networking early in your career so that when you are a specialist you have that idea of networking, as just status quo, it's the way you do it; rather than, "I'm going to sit in an ivory tower in Sydney for all of my training and might come to rural for four weeks if I have to", type thing.

So I think getting the concept of networking, that you don't belong to a hospital, you belong to a network, is something that if you develop early should hopefully continue through.

Q. And to your knowledge, is that system working well across different specialties?

A. Yes, it is. And I do have direct knowledge of that.

Q. I want to also just understand the role that UNSW has in the new precinct, the Murrumbidgee Health and Knowledge Precinct. Can you tell us a bit about that?

A. We are very proud to be part of that precinct. One of the UNSW members, not myself, is actually on the board of that precinct, and we - I like to think we bring experience

1 in developing education, of course; also research, that's
2 one of the pillars of the precinct, where we do contribute
3 with CSU around research; and also around really
4 collaborating across TAFE and nursing colleges and
5 ourselves for areas of clinical placement practice ideas;
6 multi-team work that actually I think is another area we
7 contribute there.

8
9 Q. I understand there will be a new biomedical sciences
10 building as part of that?

11 A. Yes.

12
13 Q. What opportunities will that open up?

14 A. So that is the - that's due to finish in August, and
15 that will open --

16
17 Q. August this year?

18 A. This year, and we will be moving in to it in January
19 next year. It's a three-storey building that will provide
20 all of our laboratories, all of our physiology areas, all
21 of our teaching areas, and really at the moment, we are in
22 an old nurses quarters for UNSW in Wagga. We don't have
23 enough space. The LHD very kindly have given us some space
24 to utilise temporarily and when we move into that building
25 it will be fit for purpose for our students.

26
27 Q. Is there scope by freeing up the old nurses quarters
28 that that could be reconverted to accommodation?

29 A. That is one of the things we would like to see. The
30 LHD owns the building, though, so that would be up to them.

31
32 DR WATERHOUSE: Commissioner, I have no further questions
33 for this witness.

34
35 THE COMMISSIONER: Q. Can I just ask one further
36 question. Right at the beginning when Dr Waterhouse was
37 first asking you some questions, she was talking about
38 student numbers, she calculated 282 and you said, "We're
39 going to - we expect capacity to be around 300." Can
40 I just ask, looking at the document you were shown, at
41 Wagga and Port Macquarie in year 1, in 2023, there are 26
42 students in both campuses?

43 A. Yes.

44
45 Q. Is that number and the total numbers set on the basis
46 of this is the funding capacity, or is it designed to meet
47 the demand, whatever you call it, demand or need for

1 doctors in rural/regional settings?

2 A. My understanding, it is set on the funding capacity.
3 We are funded for the 60, which is nominally 25 in Port, 25
4 in Wagga, and 10 go to Kensington.

5
6 Q. And do you have a view about whether, if there was
7 additional funding, in terms of the need for doctors in
8 regional/rural settings, that number should be greater?

9 A. Definitely.

10
11 Q. And by how much do you think? I know you can't be
12 precise about this, but --

13 A. I would --

14
15 Q. -- you might have given some thought to it, though?

16 A. We have, actually, and I would be very confident that
17 we could easily have 35, maybe even 40 at each, Wagga and
18 Port, for our first year and then follow that through.

19
20 Q. So if it was designed to meet the need for doctors in
21 regional and rural settings, those year 1 numbers for
22 students at both Wagga and Port would be 35 to 40, would
23 you say?

24 A. Correct.

25
26 THE COMMISSIONER: Thank you.

27
28 Did anything emerge out of what I just asked?

29
30 DR WATERHOUSE: We were just saying, it appears to be
31 capacity to teach.

32
33 Q. Is it correct that it's capacity to teach?

34 A. In terms of the numbers set?

35
36 Q. Yes.

37 A. The first year, my understanding is it's the funding.
38 We are funded for 60 rural entry places. After that, it's
39 capacity to teach, so year 5 and 6, and that's why we split
40 between Port and Coffs, for example, or Albury and Wagga.
41 That's my understanding.

42
43 MR MUSTON: Can I ask a quick question?

44
45 THE COMMISSIONER: Of course.

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47 <EXAMINATION BY MR MUSTON:

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MR MUSTON: Q. A moment ago you were asked a question by the Commissioner where I think he asked you about what might need to be done to meet the need?

A. Mmm-hmm.

Q. And you gave some numbers about an increase in --

A. Phase 1.

Q. In phase 1. Just to be clear, the numbers you gave, were they your assessment of the number of students who you feel, through your program, that you could --

A. Train.

Q. -- accommodate; that was not your assessment of the number of students that need to be taught or trained rurally in order to meet --

A. No, that is correct, sorry.

Q. -- the needs of the rural communities?

A. Thank you.

MR MUSTON: Thank you.

THE COMMISSIONER: Thanks. Mr Chiu, do you have any questions?

MR CHIU: Just a few questions, Commissioner.

THE COMMISSIONER: Go ahead.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. Professor, just on that topic you were asked now about potential increases in numbers, what sort of things could change to increase the capacity to teach even greater numbers, if the need is there in the community?

A. I think it would be increasing the variety of areas that we use for our training. For example, community placements are, I think, under-utilised. I'm not talking about GP placements but some of the, you know, learning pharmacology with the pharmacist, for example, and doing some rotations through rehab and those sorts of places.

The other thing is there are a lot of our smaller towns we're not utilising at the moment, primarily because

1 of the GP's workload, the thing I was saying before, about
2 they'd love to but they can't. I do think, if we had more
3 infrastructure around the community placements being
4 broader than just a practice surgery, that is one area
5 where we can broaden it. Phase 1, though, is fairly
6 straightforward because it's basic sciences.

7
8 Q. So the process could have a feedback in that if the
9 program is expanded and trains a larger number of GPs, and
10 other doctors, who stay in rural regions, that, of itself,
11 could then enable, in future, further increases?

12 A. That's my hope.

13
14 Q. Has there been any analysis done as to how many
15 doctors of different areas of specialty might need to be
16 trained in order to meet community needs?

17 A. Yes.

18
19 Q. So demand as opposed to supply, demand analysis?

20 A. Not to my knowledge.

21
22 MR CHIU: No further questions.

23
24 THE COMMISSIONER: Thank you.

25
26 Does anything come out of that?

27
28 DR WATERHOUSE: Just one question.

29
30 **<EXAMINATION BY DR WATERHOUSE:**

31
32 DR WATERHOUSE: Q. You mentioned about the need for
33 infrastructure in small towns to be able to support more
34 students. What things did you have in mind when you used
35 that --

36 A. Accommodation, for example, for the students to stay
37 in. At the moment some of ours stay in a hotel room
38 because there's nowhere to actually have them. So if you
39 were going to have more, you would need accommodation.
40 Infrastructure to help the GP practice itself, so, you
41 know, simple things like computers and rooms and things
42 like that. So it's more the logistical infrastructure
43 I was referring to there.

44
45 THE COMMISSIONER: Professor, thank you very much for your
46 time and your evidence. We are very grateful. You are
47 excused.

1
2 THE WITNESS: Thank you.
3
4 <THE WITNESS WITHDREW
5
6 THE COMMISSIONER: I have seen a message that the next
7 witness has arrived. So we can continue on until the
8 normal lunchtime, I think.
9
10 MR MUSTON: Yes. I call Kevin Lawrence.
11
12 <KEVIN ANDREW LAWRENCE, affirmed: [12.26pm]
13
14 <EXAMINATION BY MR MUSTON:
15
16 MR MUSTON: Q. Could you state your full name for the
17 record, please?
18 A. Kevin Andrew Lawrence.
19
20 Q. And you are the director of finance and performance
21 for the Murrumbidgee Local Health District?
22 A. Correct.
23
24 Q. How long have you held that role?
25 A. A little bit over four years.
26
27 Q. I understand you've prepared an outline of evidence?
28 A. Correct.
29
30 Q. Do you have a copy of that outline?
31 A. I do.
32
33 Q. Have you had an opportunity to consider it and read
34 it?
35 A. I have, yes.
36
37 Q. Does that outline reflect the evidence that you would
38 be willing to give to the Commissioner in the course of
39 these proceedings?
40 A. Correct, yes.
41
42 Q. Are you content to adopt that outline as your
43 evidence?
44 A. I am.
45
46 MR MUSTON: I tender that.
47

1 Q. In fact, I might invite you to mark it for
2 identification and then the mechanics of tendering it and
3 giving it a number we can deal with offline. We can call
4 it MFI 1

5
6 THE COMMISSIONER: It might be MFI 1, I was thinking, yes.
7 We will call it that, anyway.

8
9 **MFI #1 OUTLINE OF EVIDENCE PREPARED BY KEVIN LAWRENCE**

10
11 MR MUSTON: Q. Can I ask you, in relation to your role
12 as director of finance, you've indicated in your outline
13 that you're responsible for a range of issues. The first
14 is planning and reporting on the use of financial resources
15 and monitoring?

16 A. Correct.

17
18 Q. How does that monitoring and planning take place? Are
19 there particular mechanisms?

20 A. A small team involved in the development of budgets
21 internally, as well as the negotiations with the ministry
22 around purchase volumes. The interpretation of the service
23 level agreement that we receive effectively dictates our
24 budget, and then the machinations around allocating that
25 budget out to our units within the LHD. So that's the
26 budget setting process.

27
28 Q. In terms of that budget, the budget setting process,
29 are you engaged in the process of negotiating with the
30 ministry about how much money the LHD should be given each
31 year to deliver the services which are delivered locally?

32 A. I'm involved, yes.

33
34 Q. We might come back to that. I think you've told us
35 your portfolio includes a range of issues, financial,
36 management, accounting, which we can all --

37 A. Pretty standard sort of baseline accounting services.
38 Business partners, supporting our budget units in managing
39 their finances as well, providing the financial accounting
40 services through to, you know, preparing annual statements
41 as well. And we have a revenue transaction service. So
42 just the usual traditional type accounting services.

43
44 Q. Does that include providing those usual accounting and
45 management services to each of the various facilities
46 throughout the --

47 A. Correct.

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Q. -- LHD?

A. We have a highly centralised accounting model.

Q. You're involved, you tell us, in procurement?

A. Yes.

Q. What's your involvement in procurement, at a high level?

A. We have a team of six or eight procurement specialists, so the associate director of strategic procurement reports through to me, oversees the local procurement functions, ensures compliance with the complex rules, and currently involved in a rollout of - and I think you've heard about traceability and DeliverEASE, so those types of things.

Q. The last thing I think you tell us is one of your portfolio - included in your portfolio, is the strategic improvement office. Could you tell us what that is?

A. Yes. So otherwise known as the PMO, so the project management office. We stood that up about two years ago. We had a need to focus on improvement and what we were - where we were coming from, that we were expecting clinical managers and general managers in their day-to-day as well as doing change processes, and to be honest, the bandwidth for that clinically was just not there, so we actually provide some resources to provide governance, reporting and support to the LHD around change and improvement projects.

Q. You tell us that a health economist was engaged as part of that process?

A. Yes.

Q. What sort of role does the health economist play in that team?

A. Very early days, employed in December, so we're only a few months in. The intention is to develop a decision-making framework so that we can approach our investment decisions from an economics perspective not just a financial perspective, so looking at health outcomes and patient benefits, as well as sustainability.

Q. So when you say that, would I be right in understanding that the health economist is looking at it not only from the perspective of what sort of savings might be generated through a spend within the budget of the LHD,

1 but rather, to the extent that money is spent, what are the
2 wider economic benefits of that spend from a community
3 point of view?

4 A. Exactly.

5

6 Q. And it's, I think you say, early days?

7 A. Oh, very early days. We're very keen. It's
8 a direction that I think the state is heading into, and
9 looking at sustainability of decisions as well, it's an
10 important factor.

11

12 Q. In relation to that, do you have any engagement with,
13 locally, at least, other state government departments in
14 relation to the assessment of the economic benefits of
15 programs which the LHD --

16 A. Not locally, no. And not more broadly.

17

18 Q. So at the moment, this is an LHD initiative which is
19 confined largely in terms of its dealings to the health
20 silo, as it were?

21 A. There is a small community of practice, I suppose you
22 might call it. There are other health economists in the
23 system. So it's not a new concept, it is a new approach
24 for us down here. We do engage with the ministry and the
25 other economists in the system, very small community,
26 though.

27

28 Q. You give some examples of some of the recent projects.
29 The first is improving processes on nursing agency
30 engagement to increase efficiencies. Could you just
31 discuss a little bit what that involves and how it works?

32 A. Yeah. Sure. Coming from a governance perspective,
33 you've probably heard around the workforce issues that
34 we've encountered over the last few years, and part of what
35 we were seeing was that the engagement of agency - from
36 a governance perspective - wasn't strong. We didn't have
37 visibility. During the last --

38

39 Q. Could I ask you to pause there? The challenges that
40 you were referring to around agency, am I right in
41 assuming, is the significant spend on agency staff?

42 A. Yeah. The spend has increased significantly over the
43 last few years, particularly around nursing, but it's not
44 just confined to nursing, medical locums as well. So we
45 had a situation where the market was - I won't say
46 "cornered", because it's probably not quite the right word.
47 The whole system was crying out for workforce, as a result

1 of COVID. Much of the agency engagement was off our
2 payroll, so we actually had no visibility about the levels
3 of FTE we were engaging. We could see the costs coming
4 through the financial system. We couldn't see when they
5 were being rostered, that type of thing. So we put some
6 governance processes in through the PMO to improve that
7 governance and accountability around engagement of agency
8 and locums.

9
10 Q. What did that - or is it hoped that that will enable
11 you to do?

12 A. It has resulted in us having better visibility, and in
13 the meantime, we've finished the contract with the off
14 FTE - off-payroll report, engagement, and now nearly all of
15 our agency staff are back on payroll. So it was a blip in
16 the system if you take a longer view. So it certainly has
17 improved our governance and oversight of engagement around
18 agency staff.

19
20 Q. Has that greater information and understanding about
21 the way in which the agency staff are being retained and
22 deployed enabled you to generate any savings in relation to
23 the use of agency staff?

24 A. I don't know that we can draw those dots, connect
25 those dots up specifically. I think the move to on payroll
26 has probably been more the savings area, because we are
27 seeing savings this year. It has certainly given us better
28 visibility. It has probably enabled us to ask more
29 questions of ourselves around our staffing levels.

30
31 Q. The second project is improving reporting capabilities
32 within the rostering system so that the LHD can have more
33 oversight of the rostering system; is that a --

34 A. It's a byproduct of what we're talking about. We have
35 a rostering system called HealthRoster and I think most
36 people would agree that the reporting capability at
37 a system level is rather limited.

38
39 Q. Just pausing there, the HealthRoster system, how, in
40 broad terms, does that system get utilised? How does it
41 work?

42 A. It's on the ground. The nurse managers, the
43 department heads, will use that to roster their staff.

44
45 Q. That's a centralised computer program?

46 A. Yeah. It comes out of HealthShare.

47

1 Q. They use that centralised computer system to set the
2 rosters from the work --

3 A. Yeah.

4

5 Q. -- utilising the workforce that they've got available
6 to them?

7 A. Exactly.

8

9 Q. Does that also draw in agency staff to the extent
10 required?

11 A. Yeah. Yes, you can identify the agency staff through
12 it, through a label.

13

14 Q. And I think you said a moment ago that the reporting
15 is suboptimal through that program. Could you just expand
16 on that a little bit, what are the problems with it?

17 A. At the LHD level we really didn't have much visibility
18 around what was happening on the ground with our rosters,
19 so part of the process of what we do, when we're setting
20 budgets, is we go through and create a staff profile or
21 a nursing profile, so a ward might have 2 RNs, 3 ENs,
22 whatever the mix might be.

23

24 We couldn't really see whether those profiles were
25 being adhered to on a day-to-day basis. By accessing now
26 the HealthRoster data, we can break it down to the day, to
27 the staff category, to start looking at where the gaps are
28 and see whether clearly we can see the financial
29 implications, but we can start to identify where the gaps
30 are from a workforce perspective as well.

31

32 Q. Is that across the LHD or are you able to drill down
33 into specific facilities, so, for example, the --

34 A. Specific facilities, yes.

35

36 Q. What has that enabled you to do?

37 A. Well, it's being rolled out - again, this is one of
38 these early days things. It will enable us to have some
39 meaningful conversations and place tighter controls on our
40 staffing where we're able to, you know. Unfortunately,
41 some of the staff managers just have to get staff. So, you
42 know, some of this stuff around profile mix, skill mix, for
43 instance, is a secondary conversation; at the moment,
44 they're struggling to, you know, provide enough staff for
45 ward coverage. But that's what it will - that's where we
46 want to head but it's very early days. It's, in fact,
47 being rolled out as we --

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Q. So as a consequence of that, are there instances where, say, a more qualified staff member is being brought on to a shift because you need a staff member, you could use a less qualified staff member to meet your ratios but there's just not one available?

A. Exactly.

Q. So that obviously is having a cost implication for the LHD?

A. Yes, exactly.

Q. An EN might be a suitable person to staff a particular shift but you're only able to get access to an RN, so that's what's going in there?

A. That type example, yes.

Q. The third of the little projects is reviewing and improving the utilisation of the Transitional Aged Care Program. Could you first of all just give us a little bit of a background on what the Transitional Aged Care Program is?

A. We know it as "TACP", everything is an acronym within health. So it is a program for elderly patients, over 65, in hospital - I think it is over 50 for First Nations people. It is a program to help them transition to home and recover at home, so providing supports rather than do their recovery in the facility.

Q. So these are patients who have either been admitted through an emergency department or, alternatively, have been admitted for the purpose of a procedure?

A. Yep.

Q. Getting them out of hospital as soon as is practicable and into their homes for the recovery and rehabilitation --

A. And providing the appropriate supports for their independence and functioning, yes.

Q. A project that has been undertaken by the strategic improvement office is a review and hopeful improvement in the utilisation of that program. How have you gone about that?

A. So we have improved, it's been really quite a remarkable success story. Our occupancy - we have "beds", or places, I suppose, might be a better way of thinking of it. Our occupancy was about 60 per cent prior

1 to this, we are now consistently about 100 per cent. We
2 have a flexible model. It has resulted in revenue
3 increases of \$2 million to \$3 million a year - it varies
4 a bit depending on occupancy - but we were faced with
5 a reducing revenue stream or potentially losing some of
6 those places and those places going elsewhere.

7
8 So what the strategic office did was essentially put
9 the framework or the approach together, using the
10 ministry's approach to project management, and formed up
11 a small group, a steering group, largely of clinicians and
12 a few managers, engaged with NUMs, nurse unit managers and
13 the like, around identifying suitable patients, getting
14 them assessed and just improving the efficiency of the
15 project, of the program. As I said, there has been
16 a significant financial benefit, but also we would hope to
17 see that those clients don't readmit, they don't stay in
18 hospital, those sorts of things.

19
20 Q. The financial benefit, does that derive from the fact
21 that caring for people in their homes is more cost
22 effective from the LHD's point of view than having them in
23 an acute bed in a hospital?

24 A. Yes. Well, and we also get a revenue stream. So
25 there is a dollar per occupied place that we receive and -
26 I can't quite recall the exact rates, but increased usage
27 results in an increased revenue stream.

28
29 Q. What's the source of that revenue stream, is it state
30 or Commonwealth?

31 A. It is both. There is a state component, which is
32 lower than the Commonwealth component, so it does - but it
33 does come through NSW Health.

34
35 Q. So whilst it is early days, you are in the process,
36 you tell us, of undergoing the review of the
37 post-implementation benefits of the project, and what point
38 has that review reached?

39 A. I think the review - it has been about a year and a
40 half now. I think we've seen suitable evidence to say that
41 it's sustainable. We haven't necessarily looked at the
42 patient benefits side of it; purely from a - clearly I'm
43 coming with a finance lens. The revenue stream over the
44 last two years has increased significantly. It is still an
45 active topic of conversation in meetings and it is
46 discussed regularly at our executive table.

47

1 So I think from a - certainly the review from
2 a financial perspective is that we're very happy with it.
3 The reviews around patient outcomes and the like haven't
4 taken place.

5
6 Q. Is it anticipated that they will take place, the
7 patient outcome review?

8 A. It's on the list. We've only got the one economist,
9 unfortunately, and we are trying to tick off some
10 significant projects. It is on the list, though, and may
11 take a little bit of time. Yes.

12
13 Q. Can we move on to procurement. You tell us that the
14 LHD uses a number of shared services provided by
15 organisations like HealthShare, for example. In terms of
16 those services, one that you tell us you don't use is
17 patient transport?

18 A. Correct.

19
20 Q. That's for economic reasons associated with your
21 remoteness from Sydney, as I understand it?

22 A. Correct.

23
24 Q. Is that a decision which has been made by the LHD not
25 to use the shared service, that shared service, or is that
26 a decision which has been made by HealthShare?

27 A. Oh, it was made together a number of years ago. In
28 reality, we just are too far away from Sydney. It's not to
29 say it wouldn't be revisited. We are open to any
30 opportunity to improve service, but our internal service,
31 we have found that when we run things internally we are
32 motivated to do it well, and at this stage we're pretty
33 comfortable with the patient transport.

34
35 Q. In terms of the economic benefit for the LHD, are you
36 satisfied that running that patient transport service
37 yourself is more economically advantageous to the LHD than
38 would be the case if you were using the HealthShare
39 solution?

40 A. It didn't even get to that level of discussion, to be
41 honest. When we took - probably going back about eight
42 years now when the original decision in consultation was
43 made, it was felt that it was just too difficult at that
44 point in time, from a geographical perspective, to bring us
45 in to the HealthShare model.

46
47 Q. Is that because HealthShare - the HealthShare model

1 did not at that time incorporate a fleet of vehicles and
2 a team of drivers who were located here or anywhere
3 sufficiently close to here?

4 A. Yeah, exactly right, and I think if we were to
5 transition across, they would have to take our staff, our
6 vehicles and all that sort of stuff, but it really hasn't
7 been looked at in any great detail.

8

9 Q. From your point of view would there be any benefits,
10 do you think, to having HealthShare take over that service,
11 assuming they did take over your staff and your vehicles -
12 benefits to the LHD, I mean?

13 A. I couldn't confirm that. We would need to do the
14 work. I would say that we do run a strong service. It
15 could always be better, as everything can be, but in
16 essence, though, we have found it's very responsive. There
17 are times when it's not, obviously, but without engaging at
18 a meaningful and deeper level around what a future model
19 might look like, I really couldn't comment.

20

21 Q. Do you see benefits in the current system deriving
22 from the fact that you have - you as in the LHD has -
23 complete autonomy over exactly how that service is --

24 A. I think there is that inherent benefit, when we
25 have self-direction, to that extent. We have seen savings
26 in past years, without doubt.

27

28 The demand is an issue. You've probably heard of the
29 workforce issues at our regional sites and our rural sites,
30 so, you know, transport is increasing. It is a reality.
31 But I think there is an inherent efficiency by doing our
32 own thing, so to speak.

33

34 Q. Areas in which you are not doing your own thing
35 include linen?

36 A. Linen, yes.

37

38 Q. Food?

39 A. Food.

40

41 Q. Are there other services which --

42 A. Catering - sorry, food, yes. Cleaning.

43

44 Q. Transactional services?

45 A. Transactional, so workforce and financial accounting
46 services, payroll, those type of things.

47

1 Q. In relation to those shared services, do you perceive
2 there to be benefits associated - benefits to the LHD
3 associated with utilising them as a shared service as
4 opposed to doing it yourself?

5 A. I think so. I think from a specialist centre
6 perspective, you know, maintaining currency of knowledge
7 and practice, I think there are benefits from
8 a standardised, centralised approach, where it fits, and
9 I think transactional services is one of them. We're not
10 the only industry that has that approach. It is
11 certainly - we have no significant issues with regards the
12 provision of those services, nothing that is a burning
13 platform for us to change, drive change.

14
15 Q. What about the more tangible services like food and
16 linen - cleaning perhaps as the third: do you see benefit
17 to the LHD in utilising them as a shared service as
18 compared to sourcing those services?

19 A. Yes, years ago we did - well, linen has been
20 a centralised business unit, if you like, for a number of
21 years. We did go through the - we used to do catering and
22 cleaning ourselves. I think there is perhaps opportunity
23 to look at what the service model looks like at some of the
24 smaller sites, but in general, I think we would say that
25 the service delivery aspect is quite sound. We probably
26 would like to investigate what some of the smaller stuff
27 looks like, because the model around pass-through costs -
28 and we will probably talk about that - doesn't provide
29 enough incentive for efficiency. Those type of questions
30 are probably things that we would like to explore with
31 HealthShare.

32
33 Q. When you say "the model around pass-through costs
34 doesn't incentivise efficiency", do I take it from that
35 that you are saying that, in essence, you are compelled to
36 use the service provided centrally by HealthShare - first
37 step in the process?

38 A. We're not compelled. We have chosen to, for a number
39 of years now. So there are some LHDs that haven't got the
40 full suite of services from HealthShare. They will go
41 through their own journey with that. So --

42
43 Q. You have chosen to do it?

44 A. We have chosen, a number of years ago, to move across
45 that. Because we're not - our core business - I suppose to
46 take the core business concept, it is to look after the
47 patients.

1
2 Q. So you have chosen to do that. That service is
3 delivered by HealthShare, that has its own KPIs to deliver
4 services within its budget, but its budget is replenished,
5 to the extent that it is able to recoup the cost of
6 delivering services from you, that is the pass-through
7 aspect?

8 A. Yeah. It's - I suppose the question is around the
9 transparency and the benchmarking of pricing and having
10 visibility over that.

11
12 Q. Let's start with the first of those two concepts. In
13 terms of transparency, what do you think is lacking from
14 the perspective of the LHD?

15 A. I just - I look at them together a little bit, to be
16 honest. So the - we do - we have clear visibility about
17 what our charges are. We know --

18
19 Q. Pausing there, clear visibility in terms of you know,
20 for example, what it will cost per pillow case or per tray
21 of food?

22 A. Exactly, yes. We know the model and, you know, the
23 catering model is a fixed charge for below a certain number
24 of beds; above a certain number of beds it's based on meal
25 volumes, so we understand the model. We understand the
26 prices. We would probably seek transparency around how the
27 prices are set and whether they are competitive from
28 a value for money perspective.

29
30 Q. So have you, as an LHD, done any benchmarking of the
31 potential alternate costs of having someone else supply
32 those services?

33 A. No, we have not.

34
35 Q. Would you be able to do that benchmarking based on the
36 information you have presently available to you about the
37 service being delivered and the way in which it is priced
38 and structured by, say, HealthShare?

39 A. As we currently stand I don't think we have the
40 capability to adequately test the market.

41
42 Q. Why is that?

43 A. I just don't think we have the skill sets in that
44 area, the access to the information from other
45 jurisdictions, for instance. We could probably do a little
46 bit of internal benchmarking, and we have done that, but it
47 is very superficial. So comparing cost per meals or cost

1 per bed-day, sorry, with other LHDs or other sites. It's
2 not necessarily a great indicator. I think we would like
3 to engage with HealthShare around that aspect and work as
4 a partnership approach to understand our pricing better.

5
6 Q. Do you know - have you been told whether HealthShare
7 has done any benchmarking of the type that you have talked
8 about of its own services?

9 A. I'm not aware that they have.

10
11 Q. So moving from those shared services into procurement
12 more generally, you procure items, or the LHD procures
13 items through HealthShare. Are there any particular issues
14 that you have with that process, I think you have
15 identified several of them in paragraph 9 of your outline,
16 the first being warehousing?

17 A. I will just check that. From a process perspective,
18 no.

19
20 Q. Just pausing there, when you say "from a process
21 perspective", you mean the process by which things
22 are ordered --

23 A. Ordered, received, that type of thing. There is
24 a schedule around ordering. Every facility has a day to
25 order by and then they will receive their goods in two or
26 three days. It works well.

27
28 Q. To the extent that you are aware of it, do you see the
29 DeliverEASE and the associated reform, transparency -
30 sorry, traceability and other reform projects, being an
31 improvement to the existing process of procurement?

32 A. Oh, absolutely. We come from a pretty - we have come
33 from a pretty low IT base, from a systems ordering
34 perspective, so we're rolling out DeliverEASE as we speak.
35 Traceability has been implemented at Griffith and Wagga.
36 The feedback is good on both. We are looking at the next
37 tranche of rollout for DeliverEASE, and I think for us,
38 some of it, where we haven't quite got to now, is that it
39 actually gives us oversight of our stock levels. We
40 probably haven't quite got organised internally to begin
41 moving stock around to become more efficient in our
42 internal stock management.

43
44 Q. But as a financial controller of the LHD, that's one
45 of the benefits that you see --

46 A. Absolutely.

47

1 Q. -- coming through this new project?

2 A. Yes, active management of stock using the dashboards.
3 It's got the capability, we just haven't quite organised
4 ourselves at this point.

5

6 Q. And why do you see that, from a financial manager's
7 perspective, as being a valuable resource?

8 A. Well, I think there is a couple of things. We can
9 move stock around to, you know, reduce wastage, for
10 a start. If we don't have to order something, that reduces
11 costs as well. In the future, my understanding is that
12 DeliverEASE will move into almost an automated
13 replenishment system. It's dependent on certain tasks
14 being done for high-turnover goods in terms of cycle counts
15 and the like. So I think in the future, I think we'll move
16 into a different space.

17

18 Q. So you referenced the cycle counts and the like. Do
19 I take it that once the system is more automated in terms
20 of the way it works, that will, as you see it from
21 a financial management point of view, reduce the amount of
22 FTE each year which gets consumed by counting boxes in
23 storerooms, for example?

24 A. If we can consolidate all the little bits and pieces,
25 potentially, yes.

26

27 Q. So, coming back to - so that's the process of ordering
28 and the systems that exist. What's the issue that you see
29 with warehousing? You have described it in paragraph 9(a),
30 but if you could just develop that a little bit for us?

31 A. It's probably the freight charges. So we have seen
32 a significant increase in freight. So we used to have
33 a warehouse here in Wagga Wagga that serviced the LHD and
34 part of Southern New South Wales. It's a number of years
35 ago that we moved to the central model. So we have seen an
36 increase in freight with - our spends, in real terms, about
37 30 per cent higher than where we would have been. In and
38 of itself it is probably not - across the budget of the
39 LHD, in and of itself, it's not a significantly material
40 figure, but it is a figure that stands out to us and it's
41 a figure in terms of waste that we think potentially could
42 be better served by a different warehousing model.

43

44 Q. Again, so I understand it, the warehousing and
45 transport costs mean that you, within this LHD, are paying
46 more for an item that comes from the warehouse than someone
47 who might be more proximate to the warehouse; is that

1 right?

2 A. From a freight perspective, yes.

3

4 Q. Do you, in relation to that additional cost, receive
5 any additional funding through the ministry as part of the
6 LHD's annual budget to cover that cost?

7 A. No. No, not explicitly. There is an element for - we
8 will probably get on to the funding model in due course -
9 but not explicitly for freight.

10

11 Q. What does that 30 per cent look like in terms of
12 dollars? You tell us it's 700 --

13 A. Our total spend is about \$700,000. So, you know, it
14 is a couple of hundred thousand higher than where we would
15 have been, in real terms, adjusted for CPI and the like,
16 that we believe we're paying in excess of where we would
17 have been.

18

19 Q. So the next issue you have identified is the threshold
20 for procurement referrals. At the moment it's anything
21 over \$250,000. Could you just expand a little bit on what
22 the issue is as you see it there?

23 A. Anything over 250,000 over the life of the contract,
24 we need to go through to HealthShare for a tender. So if
25 you think of a contract that might be three years, five
26 years - let's say five - it's \$50,000 a year. It's not
27 a huge ceiling, if you like, for an expenditure contract.
28 So we go to HealthShare - over the last two years there's
29 about 18 tenders that we've done. There's a couple of
30 issues with that. There is a cost associated with that.
31 They have two types of tenders, a light tender and a full
32 tender, with different service levels. We predominantly
33 use a light tender, it costs us about \$8,000, a bit over,
34 each time.

35

36 Q. Just pausing there, is it your view that, in relation
37 to that light tender, it could be done internally and more
38 cost effectively if it was done by the --

39 A. I think there is a value for money question around the
40 light tender process, yes.

41

42 Q. Sorry, I interrupted you. You usually use the light
43 tender process?

44 A. Yeah, we do. And I think, from my memory, we've only
45 really used the full tender once, for a significant tender,
46 a multi-million dollar tender.

47

1 Probably the other issue that I would note is that by
2 doing this, we're deskilling our rural and regional
3 procurement staff as well, because they actually don't get
4 to take place - or take part in a full recruitment - not
5 recruitment, a tender process. So there is an element of
6 deskilling that is taking place. Granted, there is
7 a specialist centre and it, you know - in the eye of one
8 beholder, might have a different view to another, but our
9 perspective or my perspective would be that there are - by
10 increasing the 250 to a higher figure, we could actually
11 keep developing the skills of our people as well.

12
13 Q. So for those \$250,000-plus contracts, you've got what
14 you perceive to be perhaps economically disadvantageous
15 costs associated with the way in which that service is
16 delivered; you've got the deskilling of the workforce
17 locally to perform that same task. Are there any other
18 inefficiencies or problems that you perceive associated
19 with the need to refer those --

20 A. No, to be fair, the system does work pretty well. We
21 would query whether the amount of work that HealthShare do
22 in a light tender is worth \$8,000, is fundamentally the
23 question.

24
25 Q. What about the speed of the turnaround?

26 A. My advice would be - that I've been given is that they
27 are pretty reasonable, they do action things quickly. Yep.
28 So from a - that service delivery component, you know, we
29 don't have any complaints.

30
31 Q. Statewide contracts - you tell us in paragraph 9(d)
32 that you perceive there might be opportunities for the LHD
33 to achieve a better price than is available under the
34 statewide contracts. Could you give us perhaps an example
35 of that?

36 A. You've probably heard about the best pricing clause
37 from previous conversations, which essentially limits our
38 ability to negotiate a better price.

39
40 Q. Just pausing there to make sure my understanding of
41 the best pricing clause is the same as yours, that's the
42 provision in the statewide contracts that requires a party
43 to the contract to deliver, at the same price to everyone,
44 a particular item?

45 A. Yes.

46
47 Q. So if they do a deal for the LHD here which is cheaper

1 than the statewide price, then they have to offer that same
2 price to all of the other --

3 A. Correct, correct. The examples tend to be commercial
4 in confidence, so I will keep it pretty high level if
5 I can. There are examples where we've gone to market prior
6 to HealthShare and we've achieved a better price.
7 HealthShare have gone to market after us and then have
8 tried to bring us in to the statewide contract, even though
9 our own local contract was a better solution for us. So
10 there is that tension at that crossover point.

11
12 Q. Just in relation to that, is that a contract that the
13 LHD has entered into separately, which has then
14 subsequently become a statewide contract, which the LHD has
15 been drawn into, which has had, as its consequence, an
16 increase in the price paid by the LHD for the item?

17 A. It potentially could have. We didn't - we actually
18 went into a negotiation process with HealthShare and ended
19 up with, to be honest, a pretty reasonable outcome for the
20 state, where the contract negotiated by HealthShare had
21 some really good components - better than ours in some
22 aspects; ours was better in other aspects. So we actually
23 got a blended contract in the end. So I think the outcome,
24 when we finally got there, was quite a good contract for
25 the state.

26
27 Without going into details, that blended contract
28 certainly has been financially beneficial for the LHD.
29 What we do hear anecdotally is that representatives of the
30 suppliers do talk about that they could do better, and part
31 of this, I suppose, is the relationship, the relational
32 aspect that the locals can have with some of these
33 suppliers, that perhaps gets missed with a whole of state
34 approach. And they do reference, on occasion, the best
35 pricing clause. So there is limiting - it is limiting. To
36 what extent, financially, I couldn't tell you.

37
38 Q. You say that a lot of that is anecdotal evidence. Do
39 you have any sense, based on the position that you hold, of
40 whether that anecdotal evidence reflects reality - that is
41 to say, whilst someone might say anecdotally they've been
42 told by a representative that they could do a better price,
43 do you have any view about whether that better price, as
44 a matter of reality, could be achieved by the LHD?

45 A. I think it could, but without going through to the end
46 result, we don't know. So I think there is opportunity
47 there. That does call into question some of the pricing,

1 I suppose, with some of the statewide contracting that
2 takes place: is it really the best price? Don't know.

3

4 MR MUSTON: I note the time, Commissioner.

5

6 THE COMMISSIONER: Thank you. We will adjourn until
7 2 o'clock. Thank you.

8

9

LUNCHEON ADJOURNMENT

10

11 THE COMMISSIONER: Yes, Mr Muston?

12

13 MR MUSTON: Thank you.

14

15 Q. Can we move on to funding. Facilities within the LHD
16 fall into two categories, ABF funding and block funding?

17

A. Correct.

18

19 Q. You've expressed a view that the ABF principles are
20 sound. In what respect do you say the ABF principles are
21 sound insofar as they operate in your LHD?

22

23 A. I think the principles of ABF, from an LHD
24 perspective, they're a reasonable way to approach a funding
25 mechanism for a larger facility like the Wagga Base. I've
26 got a personal view, backed up by experience and data, that
27 perhaps below the size of Wagga Base, it's less relevant
28 and that the model becomes less pure as the smaller sites
29 are engaged in ABF funding.

29

30 THE COMMISSIONER: Q. You mean in terms of ABF, in terms
31 of a large hospital being a transparent way of recording
32 and costing activity and then later delivering an efficient
33 price, is a good model for what it is? You don't mean to
34 convey by what you've said about the principles being sound
35 that it's a model that has any - that has benefits in
36 relation to disease prevention --

37

A. No.

38

39 Q. -- developing innovative models of care --

40

A. No.

41

42 Q. -- or population health outcomes? It's a purely --

43

A. Purely a financial - absolutely, yeah.

44

45 THE COMMISSIONER: Thank you.

46

47 MR MUSTON: Q. So dealing for present purposes with the

1 funding of acute care in hospital facilities, what is it
2 about facilities smaller than Wagga Base that you think
3 makes ABF a less ideal structure for that funding?

4 A. I think the variation in price or average cost of
5 those smaller facilities, away from the state price or the
6 state average cost, depending on what you want to measure.
7 So, you know, the - I'll just take a step back.

8
9 We have two hospitals, Griffith and Deniliquin, that
10 are in the peer group, so they're in a C1 peer group and
11 a C2 peer group, and when you look at the data there, the
12 range in costs across the state, they vary from the lowest
13 to the highest by about 50 per cent. So it's quite a broad
14 range of average costs across the peer group. And my
15 perspective is twofold, is that when you get such
16 a disparity across a peer group relative to an average,
17 then the model becomes less pure and less relevant,
18 acknowledging that the ministry's funding model does
19 acknowledge that that is an issue and does attempt to
20 address that - we may talk about that later.

21
22 But there's also the operational side. Sorry, there's
23 a third component. You spread your fixed costs, which are
24 increasing, and we don't truly understand fixed and
25 variable well enough in our system to understand that, in a
26 smaller hospital, fixed costs include your salaries,
27 because you're largely on a minimum staffing level, they
28 don't move all that much with regard activity.

29
30 So to react to patient volumes in a smaller place, you
31 have less ability to do so, and less ability to absorb the
32 fixed costs of the facility. So that's my contention
33 around why it's not so appropriate from a - at a smaller
34 size facility.

35
36 Q. So in terms of the consequence of that in relation to
37 the smaller ABF funded facilities within your LHD, is it
38 your view that the funding that is delivered to the LHD
39 through that ABF model falls short of the costs incurred by
40 the LHD in providing the services which are provided
41 through those hospitals?

42 A. Yeah. The funding model has some variations from
43 a pure volume/price model. So our budget is not purely
44 built on you have a thousand widgets and we're going to pay
45 you this many dollars per widget. In fairness to the model
46 as deployed by NSW Health, they do recognise that rural and
47 regional is more expensive than metropolitan. So they have

1 this thing called a cost price adjustment, which
2 acknowledges the fact that our running rate is higher than
3 the average price, and they do an adjustment around that.
4

5 So there is an acknowledgment in the system. There is
6 an acknowledgment that the rural/regional components - and
7 specifically they have a thing called a recognised
8 structural grant, which looks at things like agency costs,
9 you know, nursing costs, transport, those type of things
10 that are more unique to the regional areas, and they make
11 allowance for that, to the extent of your existing budget.
12

13 So there is this work that is done to acknowledge it,
14 but then there's an adjustment with a cap to essentially
15 limit your budget to your existing budget. So it's a
16 little bit of a nuanced model that, in some ways, tries -
17 it's that one size fits all solution that doesn't
18 necessarily meet the outcome. And I don't - I'm not here
19 saying we need more money, but from a funding model
20 perspective, when you start adding things on, the purity
21 starts to go.
22

23 Q. So the adjustments and the add-ons, do you feel that
24 they - at least insofar as the experience in your LHD is
25 concerned, do you think that they accurately capture the
26 additional costs associated with delivering health care
27 through those smaller facilities that are ABF funded?

28 A. To the extent that you're bound by your budget. So
29 there is this reduction that then takes place, there is
30 acknowledgment that it builds up a price, or a factor, or
31 a grant, whatever terminology, but at the end of it you are
32 still limited; they just don't give you money for nothing,
33 you know. It's not an unlimited budget so we have a budget
34 to live with. So we don't get funded for what we run at,
35 and nor should we expect to.
36

37 Q. Could I just ask you to explain that a little bit
38 more. So you have a budget setting process?

39 A. Yes.
40

41 Q. And that budget incorporates an assessment of or
42 adjustments for the perceived increases in the cost of
43 delivering services in smaller rural hospitals, but is your
44 point that having arrived at that number, you are still set
45 to provide or compelled to provide the services through
46 those facilities for whatever the budget is?

47 A. For the ABF facilities, remembering the small block

1 hospitals is a separate conversation.

2

3 Q. Yes. So is there any disconnect between the budget
4 that you are given for those smaller ABF hospitals and what
5 you as an LHD need to pay out of your resources to deliver
6 those services in those locations?

7 A. Absolutely. And part of it is how it's calculated.
8 So it's based on average costs from two years ago,
9 escalated by two years' worth of CPI. So there are events
10 that happen in between that two-year period that drive cost
11 even higher, well, then, that's not actually adequately
12 resourced within - in the funding model.

13

14 So an example might be increased agency costs. So the
15 last part of last year, we saw a spike in our agency costs.
16 We won't see any benefit of that in year, or in fact the
17 year after, but the year - so two to three years out, from
18 a price setting perspective.

19

20 So there is a timing issue in terms of those unique
21 issues, you know, from a - where those costs do operate at
22 a higher rate than what is allowed for in escalation.

23

24 Q. You said a moment ago that you weren't here asking for
25 more money, but can I explore that a little bit?

26

27

28 Q. To the extent that the model which determines the
29 amount of the LHD's budget assumes a price for the delivery
30 of services through a smaller ABF hospital, and that that
31 price is, in fact, lower than the cost to the LHD of
32 delivering those services, that means that money from other
33 parts of the operation of the LHD, which might have been
34 put in to that budget, have to be taken away to fund the
35 delivery of services through the smaller hospital, doesn't
36 it?

37

38 A. Correct. So essentially, the LHD funds - sorry, the
39 ministry funds the LHD at the macro level, at the LHD
40 level. We do our machinations internally to try and
41 adequately resource the sites around, you know, their
42 running rates, and then we have some efficiency targets
43 that we build in to try to balance the budget.

43

44 Q. And so to the extent that the model - or the
45 assumption is that a particular amount of money will be
46 required to deliver services through a small hospital and,
47 in fact, that assumption underestimates the cost, where

1 within the program, the wider program of services offered
2 by the LHD, is that money being found?

3 A. It tends to be - from a principles perspective, we
4 look at the corporates, the back office, to see what
5 opportunities there may exist in there. We tend to, for
6 the non-ABF sites, essentially block fund them based on
7 their staff profile and the historical VMOs, goods and
8 services. So we don't tend to expect huge cost savings out
9 of the small sites, because they're really not there.

10
11 Q. I assume this is not a new problem?

12 A. No.

13
14 Q. Would it be fair to say that over the years, the back
15 office savings have been generated to a very large extent;
16 there's not room in the budget each year to find a whole
17 lot more savings in the back office side of things?

18 A. I think the opportunities are reducing. Absolutely.

19
20 Q. And so does that mean that in order to make up the
21 deficit in the funding of these smaller hospital sites,
22 that other services delivered by - frontline services
23 delivered by the LHD through, say, community health
24 initiatives and the like are what has to suffer?

25 A. I don't - I think from a budgeting perspective,
26 ultimately a place like Wagga Base tends to wear - Wagga
27 and Griffith primarily wear the budget deficit. That's
28 from a budget setting perspective. The linkage then to
29 service delivery is probably not quite as strong; the
30 budget doesn't necessarily drive the service delivery.

31
32 Q. How does that work? How do decisions around service
33 delivery get made from a financial perspective?

34 A. Well, this is part of the economist's role in terms of
35 setting up that framework so we have a consistent approach.
36 But what we tend to have done is look at it from
37 a financial perspective, looking also at whether it is good
38 for the patients, whether it has a lower cost of operation.

39
40 Q. So just as an example, when you're looking at it from
41 a financial perspective, I assume that's financial from the
42 perspective of the LHD's overall position?

43 A. Overall position.

44
45 Q. So the program we heard about yesterday, which was
46 aimed at diverting regular emergency department visitors
47 out of that emergency setting and into some more community

1 based and primary health care type settings, would it be
2 the case that the economics or the finances around
3 a program like that would look at what is it costing us to
4 treat people in emergency, what would it cost us to provide
5 this outreach service that diverts them from emergency to
6 other areas, does that economically result in a financial
7 saving to the LHD within its budgetary constraints?

8 A. Correct.

9
10 Q. I think you said a moment ago, that does not, at least
11 at the moment, include an assessment of whether or not
12 there are wider economic benefits associated with those
13 programs.

14 A. Yes.

15
16 Q. When I say "wider" --

17 A. Yes, things like presentations to ED in the cohort,
18 for instance, we haven't quite - yeah, there has been some
19 work done around the cohort, it needs to be taken to scale,
20 and early signs are encouraging from that particular
21 program, but from a more formal evaluation process, that
22 would be one of the things we would be looking for.

23
24 Q. What about innovation and the development of new
25 models of care that might not show an immediate financial
26 benefit, even within the constraints of - if one views
27 financial benefit only from the perspective of the LHD?

28 A. Yeah, I think it's fair to say that that's an
29 opportunity for improvement in the funding models. My
30 assessment would be that it almost - both tranches, both
31 ABF and the small hospital funding, fund for the status
32 quo, you know, acknowledging that we have volumes and we -
33 under the National Health Reform Agreement, you know, it's
34 going to be volume based.

35
36 The opportunity around investing in changes of models
37 of care or innovation tends to come outside of the formal
38 budget process. So things like the collaborative
39 commissioning, I'm sure you would have heard about that,
40 that came from a process outside of the funding model, and
41 that's the type of seed funding, if you like, that we'll
42 need going forward to change health service delivery in
43 regional and rural New South Wales.

44
45 Q. Can I ask you about the block funding locations that
46 you've mentioned. Is the amount of funding which is
47 delivered as a block for those hospitals a fair reflection

1 of what it costs the LHD to deliver services, the services
2 which are delivered through those hospitals?

3 A. It's a reflection of what they have historically
4 spent. It doesn't necessarily reflect perhaps what funding
5 or expenditure they should be doing, you know, the service
6 gap, but it is based on what they have spent two years
7 past, escalated.

8
9 There is basically a - they have a funding model that
10 they use and it's the lower of cost versus the funding
11 model, so - and they fund us at the LHD level, and then we
12 take it from there to distribute out to the facilities. So
13 from a running costs perspective historically, yes.
14 Looking forward to changing models or enhancing outcomes
15 for smaller communities, that's an opportunity.

16
17 Q. So would it be right that an increase in activity
18 through a smaller block funded facility will not, at least
19 in the budgetary cycle that we're dealing with, result in
20 any increase in the funds available to the LHD for that
21 facility?

22 A. Not in totality for the LHD. We can move from Wagga,
23 so as an example, to Tumut, which is a block funded site,
24 for instance. We can do that. There's nothing in the
25 model that precludes us from being able to do that.

26
27 Q. When you say you could do it, the LHD has an envelope
28 of money available to it?

29 A. Yeah.

30
31 Q. Which it can distribute amongst its facilities in
32 whatever way it feels most appropriate?

33 A. Absolutely, yeah.

34
35 Q. So it could move money from Wagga to Tumut, in the
36 example you've used --

37 A. Mmm-hmm.

38
39 Q. -- to deliver further services at Tumut? But in terms
40 of the amount of money that the LHD receives with respect
41 to Tumut, it stays the same?

42 A. It will stay the same unless special application is
43 made for enhanced funding.

44
45 Q. And I think you've mentioned Wagga and Griffith as
46 being two large cost centres that tend to absorb things?

47 A. Mmm-hmm.

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Q. When you say they have a capacity to absorb it, I assume there's not surplus money sitting in Wagga or Griffith to distribute amongst other smaller facilities?

A. No, no. And in fact, from a budgetary sense, they essentially cross-subsidise to an extent.

Q. But moving money away from Wagga, for example, to Tumut, to use the example you've given, would necessarily result in a reduction in something at Wagga?

A. Potentially, yes. The only barrier to that that we probably need to - I would need to table, is that recently we've been recognising - this year, recognising the Commonwealth contribution to ABF sites, so the 40 per cent or 39 per cent.

When we move activity from an ABF to an out of scope facility, we potentially lose that 40 per cent contribution from the Commonwealth. This is only pretty new, so it's a consideration that we need to, as a system, consider what that looks like.

Q. That brings me to my next question, which is: does the model that sees a facility like Tumut, for example, block funded, actively disincentivise the delivery of further procedural services, say small surgery and the like, through a facility like Tumut where it could be done in Wagga?

A. The model doesn't preclude it apart from that caveat around the national - and that's only this year.

Q. So let me ask the question again. I understand it doesn't preclude it, but from the point of view of the LHD, does it operate as a disincentive to shift surgery to a facility --

A. I don't believe so.

Q. -- like Tumut?

THE COMMISSIONER: A financial disincentive?

MR MUSTON: Q. A financial disincentive?

A. From a financial perspective, I don't believe so, and in fact, in some ways it does incentivise it, because the small hospital funding rate - so I'll just - the small hospital model has a fixed component and a variable component per NWAU. The rate for the small hospitals this

1 year is higher than the ABF rate so there is an incentive
2 to move from a price perspective.

3
4 Q. Are we talking about block funded facilities?

5 A. Block funded facilities.

6
7 Q. So a block funded facility, to the extent that you
8 perform an additional surgical list in a block funded
9 facility like Tumut, there is financial benefit to the LHD,
10 as you see it, associated with that?

11 A. To the extent of - your budget is your budget and
12 you've got to manage within it. There is nothing in the
13 model - the model doesn't change in-year, so if we do
14 something in year, it doesn't change, the budget doesn't
15 change. But if we do it and describe it appropriately to
16 the ministry or NSW Health, that we are moving from an ABF
17 site, let's say, 500 NWAU, from Wagga to Tumut, in this
18 case, it will incentivise an increased funding for the
19 small hospitals as a collective and will, in fact, reduce
20 the ABF component of our - to the extent of our budget.

21
22 Q. So again, let me understand that. You shift or
23 propose a shift of 500 NWAU's worth of small surgical
24 procedures from Wagga to Tumut. Can you just talk us
25 through how that discussion would go with the ministry?

26 A. We would - so we raised this as a principle, and this
27 is going back a number of years now, that as a strategy, we
28 should be able to move within ABF and non- - to take
29 pressure off the bigger facilities, because they are
30 running at capacity.

31
32 So the model was changed to enable that to happen. So
33 the conversations with the ABF task force or finance within
34 the ministry would - we would essentially send up a small
35 business case advising them of the change. Nothing would
36 happen in year. The purchasing negotiations discussion
37 that takes place from about January through to May would
38 cover that off, in terms of our NWAU, and if we're in a
39 growth zone, if we're in a growth period, which we are not
40 a present, there is an opportunity through those
41 negotiations, if there is funding around, to access
42 funding. So it --

43
44 THE COMMISSIONER: Q. So the funding would be increased
45 for the following year to reflect the fact that that
46 NWAU had been - those NWAU had been moved from Wagga to
47 procedures in Tumut?

1 A. Potentially.

2

3 Q. Potentially?

4 A. Yeah. And I say that because we're in a non-growth
5 zone at the moment, okay, from an overall fiscal
6 management. So by exception in this period of time,
7 potentially there may be opportunity.

8

9 We have had, in previous years, opportunities to put
10 forward enhancement cases, or business cases, if you like,
11 and they will either be funded or they won't be funded, and
12 do result, in those circumstances, in additional money.

13

14 Q. There would have to ultimately be an increase in your
15 budget, at least what you're allocated for the block
16 funding, wouldn't there, otherwise you're just missing it?

17 A. The theory of it is that if you reduce surgery at
18 Wagga, and that's your fund source.

19

20 MR MUSTON: Q. So the budget stays the same but --

21 A. In year, yeah.

22

23 Q. In year, and next year the budget stays notionally the
24 same, but --

25 A. Depending on the circumstances.

26

27 Q. -- it doesn't get reduced on account of the fact that
28 you are anticipating 500 less NWAU at Wagga, and instead
29 you've said, "500 less NWAU at Wagga but you're going to
30 have to give us a little bit more for your block funded
31 site in Tumut"; is that --

32 A. That's the principles of the funding model - to the
33 extent of the budget. I keep coming back to this, but it
34 is a limiting factor, is that we - we don't have a - you
35 know, our bucket of money is quite finite.

36

37 Q. On the assumption that shifting some surgery to Tumut
38 would not actually result in year or even next year in a
39 reduction in the amount of surgery down at Wagga but rather
40 just perhaps enable that surgery to be done quicker across
41 the board, do you see there being any likelihood that you
42 would get more, say 500 NWAU more money, to deliver that
43 surgery more quickly through --

44 A. I probably don't have visibility of the more macro
45 funding environment to answer that.

46

47 Q. But the point that you made is, in essence, there is

1 some flexibility within the block funding arrangement to
2 increase the amount of block funding at least for future
3 periods, if you either have performed more services there
4 than you had anticipated or, alternatively, if you are
5 proposing a shift in future years?

6 A. The model does allow it, yeah.

7
8 Q. The model allows it?

9 A. It allows it.

10
11 Q. You may not be involved in this decision-making, but
12 if you are, please tell us what your involvement is. When
13 decisions are made around, say, opening up a surgical list
14 at a place like Tumut, for example, or an obstetrics list
15 at Temora, for example, to what extent do - in what way are
16 the financials of it balanced with the community need and
17 the health benefits associated - community health benefits
18 associated with doing it?

19 A. So it will go through a funding or an expenditure
20 review of what that looks like. We're in unusual times
21 because we're catching up from COVID, so if you had asked
22 me that, we have deferred surgery money which we used for
23 the catch-up, and as part of that, that would be supported,
24 because there is a bucket of money to support that
25 additional activity.

26
27 The conversations in terms of correcting the issues of
28 COVID and the impacts that that's had on our surgical wait
29 list, if everything was balanced from that perspective and
30 we were at reasonable surgery levels, we would have quite
31 a detailed conversation about what it might look like at
32 Temora, how it's going to be resourced from a - you know,
33 "Is the surgeon coming up from Wagga, is it someone else?
34 What are the numbers of surgery we're looking at?" And
35 then there would be a conversation around demand at Wagga,
36 which is, you know, a bit of a moving feast sometimes
37 because it's quite large, and we'll try and balance those
38 off.

39
40 Our preference is, as an LHD, to treat people closer
41 to home if at all possible, so the model would certainly be
42 looked at through those eyes.

43
44 Q. So that's business as usual. You mentioned a moment
45 ago the deferred surgery funding. Has the LHD used that
46 deferred surgery funding to open up surgical lists in its
47 smaller facilities in order to clear a backlog, a COVID

1 induced backlog?

2 A. No. The - most of the activity has taken place
3 through Wagga and the private sector.
4

5 Q. What is the decision-making process around that in
6 terms of where that surgery is done and what types of
7 procedures are allocated to who within the private sector?

8 A. The basis - and I - the basis of decision around Wagga
9 versus Temora or a smaller site is that the wait list is at
10 Wagga. Most of the smaller sites tend not to have an
11 extended wait list, okay, so the demand for that, from that
12 backlog, is at Wagga, or Griffith to a lesser extent.
13

14 In terms of what type of surgery takes place, I don't
15 get necessarily involved, apart from a bit of modelling
16 about whether ophthalmology might be cheaper than
17 orthopaedics and that type of thing.
18

19 Q. Is your point that it's clinicians who are more
20 involved in that decision-making around which particular
21 procedures might be usefully referred out to the private
22 sector?

23 A. It's a mix between operations, so the --
24

25 Q. Who, in particular, is involved in that
26 decision-making?

27 A. So probably the two primary people, from an LHD
28 perspective that undertake the negotiations with clinicians
29 about whether they will work in certain environments, is
30 the executive director of operations as well as the
31 executive director of medical services, who is also the
32 general manager of Wagga Base at this point in time.
33

34 Q. And so that's discussions that those two individuals
35 have with clinicians within Wagga about - regarding what
36 procedures they might be able to offer and where they're
37 willing to offer those procedures?

38 A. Exactly, yes.
39

40 Q. Those are the discussions that happen. In terms of
41 the ultimate decision-making about whether a particular
42 procedure is referred out to a particular private entity,
43 how does that work?

44 A. Oh, that becomes operational. So then we have, you
45 know, a surgery management team, a small team that manage
46 that.
47

1 Q. Who is on that team?

2 A. I couldn't tell you the names of those people, sorry.
3 That's a bit removed from myself.

4
5 Q. Yes.

6 A. So, yeah, it becomes rather operational in terms of
7 filling the lists in some of these private facilities.

8
9 Q. I might move on. You mentioned a little while ago the
10 collaborative commissioning work as a way of maximising
11 services that can be provided within the financial
12 envelope. Is it right that that collaborative
13 commissioning is essentially aimed at harnessing, in a
14 collaborative way, other sources of funding which might be
15 available to people within the LHD for the delivery of
16 health services through, say, the PHN?

17 A. I think there - that is an element of it, and I think
18 that's - probably that pooling of money from, you know,
19 various levels of government is one of the opportunities
20 that we need to explore, in terms of accessing additional
21 funding for change in service delivery.

22
23 Q. Would it be right to say that that process might
24 inform the way that the LHD utilises its funding so as to
25 make it, in combination with the funding available to other
26 sources, deliver the best outcomes it can for the people
27 much the local health district?

28 A. Sorry, could you repeat that question again, sorry?
29

30 Q. I will have to remember it, first. Would it be right
31 to say that in terms of the way that that collaborative
32 commissioning process not only looks to cooperate with
33 other entities like the PHN to identify who has what money
34 where, but also informs the LHD's decision-making about
35 where it thinks it can be most strategic about deploying
36 its money to produce the outcomes that the collaborative
37 commissioning process aims to achieve?

38 A. Correct. You know, so with the PHN and other
39 stakeholders, the identification - I think it is the COPD
40 and cardiology clinic type, they're big chronic disease
41 issues for us. So that health needs aspect will drive that
42 decision-making across that or, you know, that combined
43 body, if you like, and that there's an opportunity for us
44 to address service delivery that we haven't been able to
45 necessarily address in a meaningful way.

46
47 Q. One of the bodies that the LHD no doubt - groups that

1 the LHD no doubt collaborates with is the Aboriginal
2 community controlled health organisations within the
3 district?

4 A. Mmm-hmm.

5
6 Q. First of all, is that right, that they are a group of
7 entities that the LHD collaborates with in the delivery of
8 health care?

9 A. I can't comment necessarily from a director of finance
10 perspective. But I hear - our director of Aboriginal
11 health services and others do talk about - and general
12 managers at Griffith, for instance, have close
13 relationships.

14
15 Q. From a director of finance point of view, are you
16 aware of the funding by the LHD of any programs delivered
17 through the Aboriginal community controlled health
18 organisation?

19 A. There's some small grant money that's sent through,
20 I wouldn't have the detail of that necessarily. There is
21 some small grant money.

22
23 Q. Can I move on to workforce. You tell us, consistent
24 with what others tell us, that workforce is the biggest
25 issue faced by the local health district. What do you see
26 as being the particular drivers of that challenge?

27 A. Oh, I think the rural and regional aspect is
28 significant. From what I understand, our use of premium
29 labour across the - is not different to any other rural and
30 regional area. We have seen a spike in the last 18 months
31 or so of the use of premium labour. I think it's fair to
32 say that the challenges of getting staff are becoming more
33 and more difficult, and ultimately may or may not shape
34 what health service looks like in the future.

35
36 Q. Presumably there are financial consequences brought
37 with these challenges?

38 A. Yes.

39
40 Q. To pick up on a term you used a bit earlier, are those
41 financial consequences material in the context of the
42 overall budget of the LHD?

43 A. Extremely so. Our use of overtime, for instance, has
44 increased by about 50 per cent from FY19. That comes at
45 about an 84 per cent premium, on average, so that it is
46 quite an expensive model of use of agency staff and the
47 flow-on effect of requirements around accommodation,

1 significant. Our accommodation bill has increased by about
2 \$4 million. So it is a significant - they're significant
3 buckets of money.
4

5 Our agency and locum spend in FY23 essentially
6 doubled. So yes, there - now, there is a premium aspect of
7 that, and it is a significant and material amount.
8

9 Q. Insofar as you are aware, at least, is the use of
10 agency and locums something which goes well beyond filling
11 gaps where people are sick or wanting to take leave?

12 A. I think there are some fundamental challenges in
13 filling a roster regardless of sick leave or leave.
14

15 Q. We've heard others who have given evidence who have
16 said that the use of agency staff has gone from being an
17 important supplement to the system to being a significant
18 part of the system?

19 A. Yeah. I think that's accurate and I think there are
20 sites that - and others can speak to the detail of it.
21 There are sites that almost run, not solely on agency, but
22 predominantly on agency.
23

24 Q. The costs associated or the increased costs associated
25 with heavy reliance on agency staff, locums and overtime,
26 is compromising or is having a knock-on effect in terms of
27 the services that LHD is able to offer to the community
28 within its budgetary envelope; is that right?

29 A. It's making it difficult. I think there are occasions
30 where it has been difficult to continue service delivery.
31 The day-to-day challenges are quite significant for the
32 hospital manager or the cluster manager to fill those
33 rosters, to ensure that service delivery is maintained.
34

35 THE COMMISSIONER: Q. What has caused the really big
36 increase in overtime and the use of agency and locum staff?
37 Is it pandemic driven or is there more to it than that?

38 A. Well, I'm not an workforce expert but it's post
39 pandemic. Originally I - there is a knock-on effect around
40 pandemic and I think we're not the only industry that
41 experiences that.
42

43 Q. Sure.

44 A. It seemed to happen in November/December '22, so about
45 18 months ago, when you have a look at our use of agency,
46 it spiked around that time. I don't know what the driver
47 of that may or may not have been, but I think it is

1 a flow-on effect and probably felt more acutely in regional
2 and rural New South Wales than perhaps the metropolitan
3 area.

4
5 Q. And overtime, you're not --

6 A. It's gone up nearly 50 per cent.

7
8 Q. But as to why, you're not sure?

9 A. Oh, just the people on the ground would have to work
10 overtime to fill shifts, so working double shifts, for
11 instance. And others might be able to answer that
12 question.

13
14 Q. It is all related, no doubt, to shortage?

15 A. Absolutely. Absolutely

16
17 Q. But why the sudden change is --

18 A. The whys behind it, yeah. I don't feel that I've got
19 the expertise around that.

20
21 THE COMMISSIONER: Thank you.

22
23 MR MUSTON: Q. So this has all resulted in a substantial
24 increased cost of maintaining the workforce within the LHD.
25 Has that increase in cost been reflected in an increase in
26 budget for the LHD from the ministry?

27 A. To the extent that - so last year - what year are we
28 up to - FY23, we were given some assistance for the impacts
29 of agency staff, as a one-off. We have --

30
31 Q. Pausing there, was that one-off offer of assistance
32 the equivalent of the increase or equal to the increase in
33 costs associated with the use of - heavy use of agency
34 staff?

35 A. No, it wasn't, no. And it was about the timing, to be
36 honest. That assistance took place in February and we'd
37 only had a month or two of cost impact at that point in
38 time, and we ended up having, you know, another four
39 months. Whether the ministry had enough money to cover
40 that I'm not sure, but no, it didn't.

41
42 We do get an allocation for the regional workforce
43 incentive program, so you may have heard of that in other
44 conversations. So that's a program where we offer,
45 depending on the Modified Monash Model, incentives for
46 people to come and work or stay and work. So we do get
47 a budget allocation for that, as an increase. But apart

1 from that, and a little bit of support around that, no.

2

3 Q. You mentioned the need to provide accommodation to
4 locums and agency staff. How does the LHD go about
5 securing that accommodation so that it's able to provide
6 it?

7 A. We're in competition with John Smith down the road.
8 So we do have an asset, a property management - a very
9 small team, and under pressure, as our portfolio of rentals
10 has increased significantly. But yeah, we've - we're in
11 competition with education, the police, everyone else who
12 is trying to get accommodation in towns that don't have
13 a lot of rental accommodation. And I suspect we've
14 probably driven the price, as a collective, in some of
15 those towns as well. I don't have any evidence around
16 that, but that's my suspicion.

17

18 Q. When you say you've got a small pool of accommodation,
19 does the LHD actually own rental stock that it rents out
20 to --

21 A. No. No, we rent commercially. They're residential
22 properties.

23

24 Q. There is an increasingly small - I think you said
25 a moment ago - pool of properties which the LHD has on
26 long-term lease that it uses for the purposes of rotating
27 agency staff and locums?

28 A. Yeah, it's an expanded portfolio, compared to where it
29 was, say, three years ago, driven by the requirements
30 around getting people into the regional workforce. But it
31 has expanded and does cost significantly more than what it
32 did three years ago, a few years ago.

33

34 Q. In terms of recruitment to facilities, insofar as you
35 are aware, who is responsible for the day-to-day
36 recruitment effort - that is to say, putting the ads up and
37 interviewing candidates and all of the work that might go
38 into recruiting a new nurse in a facility at, say, Finley?

39 A. It is a hybrid model is my understanding. I'm clearly
40 not the director of people and culture. We are moving to
41 more an assisted - where the central body does more. But
42 I think at the moment, you know, that that is in its
43 implementation stage. So the local cost centre manager,
44 site manager, is involved in interviews with support from
45 people and culture.

46

47 We are moving - you know, we have a centralised

1 approach to advertising; there is a central marketing
2 approach. We are moving to more a centralised - to take,
3 essentially, those functions or roles away from clinicians
4 who are busy treating patients.
5

6 Q. In paragraph 14 of your outline you talk to us about
7 VMO GPs choosing to work pursuant to sessional contracts as
8 opposed to fee for service contracts, and you point to what
9 that - the consequence that has from an economic
10 perspective. Could you just explain how that works?

11 A. So traditionally, the regional GP model would be based
12 on fee for service - come in, see a patient, get paid for
13 that patient.
14

15 Q. Just so I understand it, local GP, working in their
16 rooms in a small town like Temora, for example --

17 A. Mmm-hmm.
18

19 Q. -- they get a call from a hospital, "There's
20 a patient, presented at emergency. Could you come up?"
21 The VMO goes up to the hospital, deals with that patient in
22 emergency, they're admitted, they're not admitted, whatever
23 happens, they go through either one door or the other, and
24 the VMO returns to their rooms and continues to run their
25 GP practice. In that instance they were paid an amount of
26 money for the particular patient who came through the door
27 that they treated at the hospital?

28 A. Correct. What we are seeing now is, and in
29 recognition of that time away from their practice, the move
30 to sessional payments, where they are paid for a period of
31 time regardless of the volume of patients, because of
32 recognition that they can't see patients back - they can't
33 be in two places at once.
34

35 So we are seeing that. We are seeing an increase in
36 costs relative to activity. So we are not seeing a linear
37 correlation between activity and cost; we are actually
38 seeing pretty - you know, maybe even deteriorating or
39 decreasing activity in some of these sites, but the costs
40 are actually moving in the other direction, purely for
41 sustainability of practice and engagement of GPs.
42

43 Q. So just again, to put it in hopefully simple terms,
44 you have moved away from that fee for per service model to
45 a model where there might be four GPs in town, they might
46 agree that they'll each cover a particular block of time in
47 order to keep the hospital and the emergency department

1 open throughout the business hours of the week, maybe?

2 A. Yep, mmm-hmm.

3

4 Q. And they just get paid, effectively, to be the Monday
5 person, so another doctor gets paid to be the Tuesday
6 person, with a view to them notionally being available at
7 any time on, say, Monday?

8 A. Yes, if there is a second person. Yes, correct. So -
9 exactly.

10

11 Q. In terms of the costs associated with that sessional
12 model, do you have any sense of how that would compare with
13 having a staff specialist employed permanently in that
14 hospital or a roster of some --

15 A. I've not done the modelling on that, no.

16

17 Q. Is there any idea of - having not done modelling, you
18 may have no idea, but have you got any sense of whether
19 there is --

20 A. No. It's probably a question best for the DMS, who
21 would have, because he's more acutely aware of the
22 remuneration rates. I'd have to go - I am an accountant.
23 I would have to go and do the model.

24

25 Q. The last thing that you've told us about in
26 paragraph 17 of your statement is data and, in particular,
27 the challenges presented by the absence of data for
28 patients who trickle in to Victoria and the ACT. Could you
29 just explain what those challenges are or how they manifest
30 themselves in the context of what you do?

31 A. Yeah. So we have a long border with Victoria, we
32 border with the ACT. So from a service planning
33 perspective, we actually don't get to see what the whole of
34 our health looks like, because we actually don't treat
35 significant proportions of our population.

36

37 Having access to that data in a more timely fashion
38 from a service planning, you know, a health needs - you
39 know, even the evaluation whether of we should stand up
40 a service that may be done across the border, for instance,
41 needs data, and we don't necessarily get that data in a
42 very timely fashion. We don't have a connected-up data
43 system or EMRs and all that sort of stuff with other states
44 and that's probably - won't happen in my working life, but
45 that's - something like that would be really good.

46

47 But there's also, you know, non-admitted activity.

1 What are people going across the border for, to receive
2 services for? We don't have that visibility.

3
4 Q. So in the context of, say, a renal patient who might
5 live down near the border and travel into Victoria to have
6 their renal treatment, is your point that, as an LHD,
7 because they're having their treatment in Victoria, and
8 this data is not available quickly and readily, you don't
9 necessarily have a good view of how many patients there
10 are in a particular corner of your LHD using renal
11 services, which informs decision-making about whether or
12 not you as an LHD should stand up a renal chair in a
13 particular corner - that particular corner of your LHD?

14 A. Correct. There may be branches and, you know, the
15 specific details of renal, for instance, there may be
16 branches within NSW Health that have access to that type of
17 data. Again, it won't be necessarily current, because it
18 normally takes a year or two for data cleansing and all
19 that sort of stuff. So from an LHD perspective around that
20 planning aspect, we don't have visibilities.

21
22 Q. From the point of view of that financial manager of
23 the LHD, do you see any other challenges presented by the
24 way that the ministry allocates funds to your LHD, the
25 process?

26 A. I think part of - if I was to wish upon a star, so to
27 speak, around --

28
29 Q. Yes, if we gave you the magic wand?

30 A. A magic wand, that was - that might have been the
31 terminology.

32
33 Q. The Commissioner used the magic wand. I prefer to use
34 the analogy of a genie, but --

35 A. I'll go with magic wand because the boss said. The
36 funding model as it stands is really volume based, and we
37 understand why that has to be, because of, you know, the
38 national stuff. Not particularly outcomes focused. There
39 is a little bit of incentive stuff in there, but it's not
40 material to make changes, and the ministry acknowledge
41 that, and they're thinking about what that looks like.

42
43 Health promotion, health prevention, you know, that
44 lifestyle determinants of health is almost absent in terms
45 of, you know, that generational change that is required to
46 improve the health. I don't think the model necessarily
47 acknowledges service gaps very well in terms of rural and

1 regional challenges, and it certainly doesn't incentivise
2 alternate models of care. So there are some of the things,
3 from a - you know, that patient focus that the model
4 doesn't necessarily view. The status quo within the
5 context of your own budget is there, but changing the way
6 we do business is not, and I suppose, you know, we refer -
7 you know, the quote, if we continue to do the same, we'll
8 get the same, sort of thing, and that's sort of where
9 I sit.

10
11 Q. So, for example, coming to your comment about filling
12 the gaps, if there was a gap in the delivery of primary
13 health care in a particular part of your LHD, do you see
14 the existing model by which the LHD is funded by the
15 ministry as giving you the financial ability, at least, to
16 fill that gap with a state funded service?

17 A. I would have to question whether we would want to -
18 it's not our responsibility, but in terms of providing
19 healthcare needs, we may be the last provider of the
20 service.

21
22 So at this point in time, we would need to approach
23 the ministry and perhaps the Commonwealth, because there's
24 a shifting, you know, in terms of responsibilities that
25 needs to be negotiated, but that mechanism is there. It's
26 not in the formal service level funding model, but that
27 flexibility for conversations is certainly there with
28 regard accessing funding through the ministry and the
29 conversations that may or may not take place with the
30 Commonwealth.

31
32 Q. When you talk about responsibilities, do I gather what
33 you're referring to is the fact that the funding source,
34 the existing funding source for primary health care is the
35 Commonwealth funded MBS system?

36 A. Yes.

37
38 Q. And you do not perceive the state or the LHD as having
39 a role in being a funding source for that --

40 A. We can access the MBS - with, you know, a staff
41 specialist, for instance, we can access MBS funding. Now,
42 whether it's enough to incentivise a staff specialist
43 clinic of some sort, from a - but I'm not sure that from
44 a - let's be a bit more general. We want to be in the
45 business of employing GPs, for instance, but that's not
46 necessarily our remit. We're clearly a player in it. I'm
47 sure other people will have a view about that. But the

1 funding model as it stands doesn't incentivise that.

2

3 Q. Why not?

4 A. Because it's based on history, largely. It's based on
5 DNR - or, sorry, clinical costing information from years
6 gone by. There is a mechanism, as I said, to discuss the
7 challenge and the issue and seek a way forward through the
8 ministry, no doubt.

9

10 So we're not locked and loaded into the funding model,
11 there is the flexibility on a case-by-case scenario to
12 approach the ministry and - who would advocate whichever
13 way to access Commonwealth funding or the like.

14

15 Q. You've said a couple of times that you're not sure
16 that the LHD would want to get into the funding of or the
17 delivery of primary health care. There are areas within
18 your LHD where the market based system is not effectively
19 delivering primary health care to sections of the
20 population. Do you recognise that?

21 A. I'm not close - as a director of finance I'm not close
22 to that type of thing. I think we recognise there are
23 pockets of failure.

24

25 Q. To the extent that those pockets exist and the
26 existing market-based system is not, for whatever reason,
27 delivering primary health care to sections of the
28 population within the LHD, who do you see should be doing
29 that?

30 A. I think there's a collaboration between the PHN, the
31 LHD, the Commonwealth and NSW Health. I don't necessarily
32 see - and again I'm probably not the specialist in this
33 area - that we would go it alone.

34

35 Q. Change topics ever so slightly. The budgetary cycles
36 that you work to are an annual cycle; is that right?

37 A. Correct.

38

39 Q. Are there any challenges presented by that fact which
40 you think would be overcome if the budgetary cycles were a
41 little bit longer?

42 A. I would welcome a longer, three- or four-year cycle.

43

44 Q. Why?

45 A. It just gives a little bit of stability, a little bit
46 of surety.

47

1 Q. What would that stability give you in terms of - or
2 give the LHD in terms of its capacity to meet the needs,
3 the health needs, of the community?

4 A. It certainly would assist. But to the extent that we
5 don't get a formal allocation, we do have a sense of what
6 our budget is looking forward. It won't be the final
7 budget. We get that each year. But it would be - and, you
8 know, we're part of a bigger ecosystem so it's easy to sit
9 here, I - it is a complex funding environment. Sure,
10 a three- or four-year period would assist us be able to
11 plan a bit better.

12
13 Q. You tell us that you have a sense each year of what
14 you're going to get, which no doubt gives you an ability
15 with some consistency and stability to provide a range of
16 services that you feel will fall within that block of
17 money. What is it that you would - greater certainty over,
18 say, a three- or four-year period would give you in terms
19 of as an LHD to provide consistency and stability in the
20 delivery of health care?

21 A. I think just for our units, you know, just to set
22 a three- or four-year budget would give them the
23 opportunity. Whilst we know what the next three or four
24 looks like materially, each year we're hit with efficiency
25 dividends, for instance. Now, they're not material, but
26 they do take - you know, the pie is getting smaller and
27 smaller. So some surety around that in the absence of the
28 political cycle - and I probably shouldn't go there - but
29 would give us some stability in planning and be able to
30 think a bit more longer term about what redesign might look
31 like.

32
33 Q. Is that because the implementation of new models of
34 care to test redesign principles and the like are those
35 things that money is found at the peripheries for them, and
36 that's the money that you don't know with certainty beyond
37 the current budgetary cycle that you will have?

38 A. And it takes time.

39
40 THE COMMISSIONER: Q. Takes time to evaluate?

41 A. Well, develop, evaluate, consult. You know, I think
42 it is important that we actually collaborate with the
43 stakeholders, and it just doesn't happen quickly,
44 unfortunately.

45
46 MR MUSTON: Q. You said a moment ago that there were
47 challenges presented by the political cycle and showed

- 1 a resistance to going there. I would encourage you to go
2 there. What is it that you see about the political cycle
3 which has an impact, positive or negative, on the way in
4 which the LHD is able to deliver health services to its
5 community?
6 A. I think - and as is the right of the government of the
7 day, to pivot towards their priorities, but that can have
8 an effect on the ground.
9
10 Q. In what way?
11 A. Well, we might be going in one direction with
12 a funding source and that stops and we're going in a
13 different direction for something else. It just then does
14 take a bit of time to pivot. As an LHD, we're not quick at
15 change. The cycle - and as I said, it is the government's
16 right, we are a public funded organisation. But the
17 political cycle can impact funding, particularly program
18 funding, if it's not a priority, for instance - yeah.
19
20 Q. In relation to that, one thing that - one feature of
21 the political cycle is announcements about rebuilds and
22 upgrades of particular hospital facilities? You nodded.
23 I take that as a yes.
24 A. Correct.
25
26 Q. You, as an LHD, receive infrastructure funding when an
27 upgrade or a redevelopment is announced?
28 A. Correct.
29
30 Q. And that infrastructure funding covers the planning
31 and building of the new hospital or the renovation of the
32 existing hospital?
33 A. Generally through health infrastructure, correct.
34
35 Q. Would it be right that a new hospital or an upgraded
36 hospital will occasionally, if not always, cost more to run
37 than the old, perhaps smaller footprinted hospital?
38 A. I think that's a fair statement.
39
40 Q. And in terms of the way in which funding is allocated
41 from the ministry to the LHD in the years after the ribbon
42 is cut, if I could use that term, is there an increase in
43 the funding provided to the LHD to run that hospital?
44 A. From an operating perspective?
45
46 Q. Yes.
47 A. That's changed in the last few years, so the answer is

1 yes. It's based on what we call a financial impact
2 statement, which tends to - has tended to be a little bit
3 old, it's done through the approval process. There is
4 a change, a positive change, this year in terms of we are
5 getting an opportunity to revisit what our running costs
6 look like.

7
8 Now, whether we get the full extent of that, I can't
9 say, but there is recurrent funding for new builds. It's
10 an area - it's been a bit of a grey area, an uncertain
11 area, at a system level, for a number of years but there is
12 that aspect of it that wasn't there six, seven, eight years
13 ago.

14
15 Q. Even as it currently stands, in its improved state,
16 does that uncertainty about the ongoing funding for the
17 running of more expensive facilities compromise the LHD's
18 ability to flex into other areas of innovation or
19 community-based care within its existing funding envelope?

20 A. I don't - just repeat that one again? We're linking
21 the --

22
23 Q. So to the extent that there is uncertainty around
24 whether or not there will be adequate budgetary support
25 provided for the increased cost of running a new hospital,
26 does that uncertainty translate into any - well, how does
27 that uncertainty translate on the ground in terms of the
28 services, other services, that the LHD is able to provide?

29 A. In terms of the other services, it probably doesn't
30 have a direct impact. In terms of the services at that
31 facility, until we get those operating costs and understand
32 what that looks like from year 1 going out, we won't go and
33 employ, you know, support staff, for instance, or - there
34 may be - the business case might have we require two more
35 asset people or maintenance people to be engaged. So we
36 make an evaluation when that money comes through or the
37 budget comes through of what we can and can't afford to
38 stand up, based on what the funding is.

39
40 Q. I will ask you this last question as the financial
41 operator or the financial controller of the LHD. Are there
42 any other issues that you think are important issues to the
43 way in which the LHD operates, financially, which we
44 haven't canvassed today, that you would like to raise?

45 A. No. I think we've covered most of the aspects.

46
47 MR MUSTON: No further questions for this witness,

1 thank you, Commissioner.

2

3 MR CHIU: No questions.

4

5 THE COMMISSIONER: Thank you very much for your time and
6 evidence, sir. It's greatly appreciated. You are excused.

7

8 <THE WITNESS WITHDREW

9

10 THE COMMISSIONER: Yes, Dr Waterhouse?

11

12 DR WATERHOUSE: I call Dean Marchioni.

13

14 <DEAN ANDREW MARCHIONI, affirmed: [3.00pm]

15

16 <EXAMINATION BY DR WATERHOUSE:

17

18 DR WATERHOUSE: Q. Mr Marchioni, can you please state
19 your full name for the record?

20 A. Dean Andrew Marchioni.

21

22 Q. And you are the cluster manager for the
23 Narrandera/Leeton cluster in Murrumbidgee Local Health
24 District?

25 A. That's true.

26

27 Q. How long have you been in this role?

28 A. I've been in this role since April 18 last year.

29

30 Q. And what position were you in before that?

31 A. So I was a nurse manager, patient flow.

32

33 Q. What did that involve?

34 A. So it was, I guess, working in a telehealth setting,
35 working with clinicians on the ground, through virtual
36 health, connecting nurses on the ground in the ED, or on
37 the ward, to the appropriate clinician for what their needs
38 were, whether it be a doctor or a Virtual Nurse Assist,
39 supportive space.

40

41 Q. I understand that you previously trained as a clinical
42 nurse; is that correct?

43 A. Yes, that's right.

44

45 Q. So what fields of nursing did you work in?

46 A. Very broad experience. So started in the new grad
47 area working in surgical, medical, orthopaedic. I've

1 worked in theatre as a scrub nurse and - yes, as a scrub
2 nurse. I've worked remote area nursing, worked in critical
3 care, so ICU, several tertiary sites, emergency
4 departments, I've worked as clinical a nurse consultant
5 in - for surgery, manager of a couple of small sites, and
6 I've acted as a cluster manager on several occasions over
7 a number of years.

8
9 Q. I'm going to come back to what you do as a cluster
10 manager in just a moment, but before that, I'd like to just
11 get a bit of a feel for the five facilities that are in
12 your cluster. So if we could start with the Narrandera
13 health service, can you just outline the services that that
14 provides?

15 A. Yeah, so Narrandera is an acute space, they have, say,
16 20-bed acute - 20 acute beds, five emergency department
17 beds. They have a community health, an allied health
18 setting, transitional settings, so back into sort of rehab
19 outreach, so transitioning people from hospital, who have
20 been there long term, back to their home.

21
22 Q. So that's transitional when they've been in hospital
23 for a while and then they are trying to rehabilitate them
24 to get home; is that what you mean?

25 A. Yeah, that's right. So it is a Transitional Aged Care
26 Program, actually. They have theatre, so they operate
27 there roughly 15 times a year, generally through the months
28 of February through November. There is a bit of a lull
29 over a period of Christmas and January. I think that's
30 about it.

31
32 Q. So with the 20 beds, does that include the
33 transitional beds or are there more beds for the
34 transitional unit?

35 A. No, that includes those beds.

36
37 Q. How many staff does it take to operate that facility?

38 A. The total FTE? Or just day to day?

39
40 Q. Maybe you could look at it in terms of nursing staff
41 compared to allied health, doctors, that sort of thing?

42 A. It's a difficult question to answer. It's quite a -
43 it's broad. So for the morning shift, for example, you
44 have two RNs, an EN - or and two ENs. You have a nurse
45 unit manager and a clinical nurse educator. That's Monday
46 to Friday. They don't - the nurse unit manager and
47 the clinical nurse educator are not there on the weekends

1 or after hours. The evening shift is the same, so two RNs,
2 two ENs, and night duty is two RNs and one EN.

3

4 Q. What about the medical staffing there?

5 A. So for Narrandera; it's a GP VMO model. I was
6 listening to the previous person talking, they essentially
7 put their hand up to work, or they don't. So the GP - the
8 perfect model would be that we have a GP VMO on call for
9 the hospital for both our acute patients and for our ED,
10 the idea would be great, to have 24-hour care. That isn't
11 the case at the moment. So, for example, Narrandera,
12 Tuesday and today, are on remote medical consultation. So
13 all of their care is via - for the ED is via telehealth or
14 virtual health, with a doctor who is offsite.

15

16 Q. And so how many GPs are there in the town, do you
17 know?

18 A. In the town, there's one GP practice. He's been there
19 a long time and has done a fabulous job, I would say.
20 There's currently five. Not full time.

21

22 Q. And how many of them work in the hospital?

23 A. All of them do, or have - they have a contract with
24 us, yes.

25

26 Q. What about Leeton? Can you give me a bit of a picture
27 of Leeton, along the same lines, what services does it
28 have?

29 A. Yeah, so very similar, so they have an ED, it's a busy
30 ED, they have a busy acute ward, similar numbers. They do
31 not have a theatre but they have a midwifery group practice
32 service. So they do low-level or low acuity midwifery
33 practice services.

34

35 They have community health, allied health. Yeah.

36

37 Q. What are the allied health services at Leeton and
38 Narrandera?

39 A. So very similar, so occupational therapy, physio,
40 dietician, nutrition, virtual - no, that's gone. Yes.

41

42 Q. That's all on site, is it?

43 A. It is, that's right.

44

45 Q. Now, I move to the multipurpose services. I gather
46 there are three in the cluster?

47 A. There are.

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Q. So can you tell me a bit about Hillston MPS?

A. Yes. So Hillston is - so the MPS, just assume that everybody knows MPS is an acute model with a residential aged care attached, with an emergency department. So Hillston is an 11-bed aged care and three-bedded acute care with two emergency department spaces. They have a GP VMO who is very connected to the community and is, I must say, on call for eight out of 10 days.

Q. And how does the nursing staff for the Hillston MPS compare to what you were describing for Narrandera?

A. Well, it's just less in numbers. So they have a registered nurse - so Monday to Friday, they have a facility manager and a clinical nurse educator who works 0.6, so not full time, and there's a registered nurse, an EN and an AIN, morning shift, afternoon shift, and at night-time they have a registered nurse and an enrolled nurse.

Q. Can you just explain for the record what an AIN is?

A. It's an assistant in nursing, so it's a TAFE course through a Cert III in Assistant in Nursing.

Q. Can you give us just a very brief outline of the differences between an assistant in nursing, an enrolled nurse and a registered nurse in terms of what they can do?

A. Assistant in nursing is very - much more focused on personal care, they are unable to deliver medications and they don't - they are not a registered practitioner.

The enrolled nurse and registered nurses are both registered through AHPRA and the slight difference really is about medication, in charge and access to some of the IT HealthRoster and these sorts of things. I think there's much more than that, but the basis of it --

Q. That's probably enough, just so that we have an understanding, that's okay. So the Lake Cargelligo MPS, how does that compare to Hillston?

A. So that's a 16-bed aged care and a six-bed acute care, and three-bedded or three-chaired or three-seated emergency department. Similar services. They have a physio that works there four days a week, they have an OT that's connected - not on site. Nutrition and dietician are accessed through telehealth through the community care intake service. Again, you have a facility manager, they

1 have a deputy nurse manager, on top of - in that leadership
2 role; we have a clinical nurse educator, 0.6 again, and
3 their day-to-day running is two RNs, two ENs and an AIN
4 through the morning; and the evenings, two RNs, an EN and
5 an AIN; at night-time they drop back to just one RN and one
6 EN.

7
8 Q. And the Lockhart MPS?

9 A. Again, there's a 15-bedded aged care, five-bedded
10 acute, two-bedded ED. Sorry, I should go back, if I can,
11 go back to Lake Cargelligo, they also have a very well
12 connected GP VMO who is very similar, you know, 80 per cent
13 on call to support the community. Sorry. I did forget to
14 mention that.

15
16 So Lockhart, 15-bed aged care, five-bed acute,
17 two-bedded ED. Facility manager - similar type of service.
18 The CNE works 0.4. They have on site - a physio who is
19 a visitor, so they are an extension of Wagga and they come
20 out one day a week, so they're not on site, and they run
21 programs for the community plus supporting our acute space.
22 Occupational therapist there who is two days a week. They
23 have a community health that does all things community
24 health do.

25
26 Q. And are the MPSs integrated models whereby the staff
27 are moving between the aged care residents and any acute
28 people or any acutely unwell people that are there?

29 A. Yeah. On a whole, the answer would be yes. The
30 assistants in nursing generally stick with the aged care
31 space, because some of the acute space, with IV lines and
32 some of the clinical care, they can't deliver, but they
33 certainly do go into the ED, into acute care.

34
35 Q. Can you give us a sense of the distance between the
36 five facilities in terms of driving times and so on?

37 A. I can, because I'm travelling there quite often. So
38 Lockhart is 80 kilometres from Wagga, or thereabouts;
39 a further 60 kilometres to Narrandera; 30 kilometres west
40 then to - 35 kilometres further west to Leeton; from Leeton
41 to Lake Cargelligo is about an hour and a half, two hours,
42 it's 150, 180 kilometres; and Lake Cargelligo and Hillston
43 are 100 kilometres apart. So I think, I'd say, the tyranny
44 of distance is difficult.

45
46 Q. How often would a patient need to be transferred out
47 of one of those facilities to, say, Wagga or Canberra or

1 Melbourne, for care?

2 A. Certainly the district sites of Leeton and Narrandera,
3 transfer more people than the other sites. I don't have
4 the data, and I hadn't thought about looking that up, to be
5 honest. Anecdotally, Lockhart will transfer one person
6 a week to Wagga. Hillston, we do the same, Lake Cargelligo
7 is a bit busier and they transfer more people to Griffith.

8

9 We do transfer people out of those sites to Canberra,
10 to Sydney, but they are critical care - they are our
11 critical care patients and, you know, that's not a common
12 occurrence, it's just when they happen. So they're a very
13 unwell patient who will be ventilated and the team fly from
14 Canberra or Sydney or Royal Flying Doctor type service, air
15 New South Wales - air ambulance, sorry, New South Wales,
16 would come to the site to help care for.

17

18 Q. So looking, then, at your role - I know you travel
19 a lot for those - for the different sites, where are you
20 based day-to-day? Do you start off in Wagga? Do you go to
21 each site?

22 A. No, I certainly don't go to each site, no, not daily.
23 I go probably fortnightly to each site, maybe at least
24 monthly to each site and it just is variable. So, I mean,
25 I started today in Leeton and I was in Narrandera and then
26 quickly back here. Tomorrow I will go back to Leeton and
27 to Narrandera or to Narrandera first then to Leeton and
28 I will stay overnight, and Friday back to Leeton to start
29 the day and finish the day in Narrandera.

30

31 Q. What does your role involve? Apart from all of the
32 driving, what do you actually do day-to-day - sorry, not
33 day-to-day but across the month or whatever, in terms of,
34 say, quality and safety type activities?

35 A. Yeah, so I mean, my role is really to empower and to
36 help support the leadership space within the - within each
37 hospital. But on top of that I guess my role is in
38 governing the patient safety and quality.

39

40 So yesterday, we had a patient safety and quality
41 meeting and so I talked with our patient safety and quality
42 manager and we had a meeting and talked about all things
43 patient safety and quality. Revenue, money in and out,
44 patient care in and out.

45

46 Q. What does the revenue money aspect involve?

47 A. So I guess for our staff to understand what it costs

1 to run a hospital and where that money should go, what the
2 type of care and, you know, addressing KPIs through our ED
3 and our lengths of stay, I guess even to communicating with
4 the doctors so they understand there are certain things
5 happening. Say, for example, EMR, our electronic medical
6 records, are having down-time this Saturday night, so it
7 will be part of my job to help govern the space so that
8 everybody is going to be aware, so there are systems in
9 place to support that we're not using computers on Saturday
10 night and we've got all our paper based systems in place.

11

12 Q. Do you have a role in asset management or facility
13 management?

14 A. Definitely, yeah. So we communicate with asset on
15 a regular basis and we look for opportunities for growth,
16 to ensure that the facilities are being maintained properly
17 and things are being fixed or - you know, kept up to
18 standard and through the guidelines, policies, so test and
19 tag electrical equipment, make sure our beds are rotated
20 through and maintained and safe, as an example.

21

22 Q. In general terms, how old are the facilities that are
23 in your cluster?

24 A. So Lockhart, I'll say, is 12 years old. Hillston is
25 12 years old. Lake Cargelligo I would - I actually don't
26 know but it's old, 25 years old. Leeton and Narrandera,
27 well, 1800s, they were both built, and still doing - they
28 don't look the same as they did back then but they've been
29 maintained and upgraded and fixed, yeah.

30

31 Q. Now, I understand that you have a role, also, in terms
32 of workforce; is that correct - about recruitment and
33 retention of workforce, that is?

34 A. Absolutely. As the previous speaker said, it takes
35 up a --

36

37 Q. I will touch on some of the things that he raised as
38 well. So is this just for nursing staff or do you also
39 oversee the recruitment and retention of medical and allied
40 health staff?

41 A. Certainly for medical, we oversee, allied health and,
42 yeah, nursing, and nursing is the biggest part of that, but
43 certainly oversee anyone and anyone that - administration,
44 you know, asset maintenance, all that stuff.

45

46 Q. So just starting with nursing because, that is your
47 biggest workforce, do you find recruitment and retention is

- 1 challenging at your - at these sites?
2 A. To say the least, yes, absolutely.
3
4 Q. Is it the same issues at all of the sites or are some
5 better or worse than others?
6 A. Yeah, the same issues but, yeah, it is different in
7 each site, absolutely.
8
9 Q. Which sites are particularly challenging for you?
10 A. Leeton and Narrandera.
11
12 Q. So the bigger hospitals?
13 A. The bigger space - and Lake Cargelligo, they're the
14 three spaces that are the most challenging over the time
15 I've been in this role.
16
17 Q. Why do you think there's some reluctance for nurses to
18 come and work in these sorts of facilities?
19 A. I would put it down to the skill set required, in
20 particular through the registered nurse. The skill set
21 required to be in charge of a hospital, in particular those
22 after hours, is substantial. You need a great deal of
23 skill and experience, capability in a leadership space to
24 know how to handle anything that could happen at any time.
25 So those people aren't easy to find. Certainly we've found
26 difficulty in growing them, as well. I think there seems
27 to be a growing population who want to work part time and
28 not full time. That is difficult.
29
30 Q. Are there opportunities for job sharing when that
31 occurs?
32 A. Mmm, yes.
33
34 Q. Does that help to resolve the situation?
35 A. Oh, look, I'll say no, but it's - it has and it can;
36 it just doesn't always.
37
38 Q. Are there less issues then, or fewer issues, I should
39 say, with enrolled nurses and AINs compared to registers
40 nurses?
41 A. Certainly for the five sites that I'm looking after,
42 our EN workforce is almost full. The retention and
43 attraction for those guys, or for those staff members, has
44 been great.
45
46 Q. Why do you think that is? Why is it different?
47 A. Oh, I really don't know. I have some theories, but

1 nothing to grab on to.

2

3 Q. Are there opportunities for enrolled nurses to become
4 registered nurses with further training?

5 A. Yeah, absolutely. So there's been some great
6 initiatives through, you know, whether it be NSW Health and
7 the universities board or the TAFE. So through AIN, if
8 you're an AIN you can actually get into a TAFE course at
9 the moment for free and then do your ENs, and then once
10 you've done that you can actually then graduate into
11 registered nursing, there's opportunities to step into
12 that. So yeah, there definitely is, yes. And that word is
13 spread round, we promote anybody's growth. If you want to
14 be an AIN that's fine. If you want to be an EN, we would
15 do everything we can, or I certainly would, to support you
16 to entice you to stay.

17

18 Q. And do some take that up?

19 A. Yeah, they have, yeah.

20

21 Q. How often would that happen?

22 A. Not often. No.

23

24 Q. But we have heard about the Virtual Nurse Assist
25 program, which is aimed at supporting, in particular, the
26 more junior nurses when they go out to more rural sites.

27 A. Mmm.

28

29 Q. Is that something that some of those registered nurses
30 could tap into if they're running a hospital, to support
31 them after hours?

32 A. Yeah. Yes, they can.

33

34 Q. And they do that?

35 A. Yes, they do. I don't think they do it as often as
36 I would like them to, or I think that would be helpful to
37 them, but certainly they do. My view on that would be that
38 they want somebody that they can see and discuss something
39 with face to face rather than on a phone. Mostly there's
40 somebody they don't know and they want to connect with
41 somebody they do, and that may be the CNE or the facility
42 manager.

43

44 Q. How does working in some of these relatively isolated
45 sort of situations affect the nurses' workloads?

46 A. Well, certainly it takes more time, so as an example,
47 it would be if you have a doctor on site, who can see,

1 touch and feel the patient, you get a quicker resolution as
2 opposed to making a phone call and getting somebody else
3 online, if that makes sense. So people might stay a little
4 longer or the nurse is asked to do a little bit more and
5 perhaps be a little bit more thorough. I don't necessarily
6 think that's a bad thing, but it's more time is needed for
7 the nurse and, again, a greater level of skill to be able
8 to, one, listen to a chest appropriately or do a clinical
9 finding, palpate a belly, check out a rash, and then know
10 what that means.

11
12 Q. And when you say they're asked to do a little more, is
13 that in terms of extending their scope of practice at all,
14 that it's beyond what they would be doing in, say, Wagga
15 Base Hospital?

16 A. No, not necessarily, no. No, what I mean is that you
17 know, in the combination with onsite doctor and nurse,
18 a nurse will do an A-G assessment for example and the
19 doctor will come and do another A-G assessment that's
20 slightly different. So the primary survey and the
21 secondary survey would all occur in a similar time frame by
22 two different clinicians.

23
24 Q. Were there any effects with COVID in terms of impact
25 on staff --

26 A. Yeah.

27
28 Q. -- in your cluster? Can you outline some of those?

29 A. I heard it mentioned earlier as well, it's - the
30 staffing, not the profile of the establishment but the
31 staffing availability dropped off, so we had been reliant
32 upon agency staff for some time, and through COVID, those
33 international nurses that would be - often are or agency
34 staff, that had come from New Zealand and India and the UK,
35 lots of different countries, to be honest, but they could
36 no longer come to fill the void. So the nurses on the
37 ground are working extended hours to fill gaps, I guess,.

38
39 I would add that there is some trauma or some stress
40 in relationship to, you know, we're in the business of
41 caring for people, so when you limit family coming in, and
42 through those COVID times where we were shutting hospitals
43 down, external people coming in or making it very
44 difficult, that caused stress. The timeliness of masks,
45 gowns, you know, you've got an eight-hour day, you're
46 spending four hours a day taking your gown on and off and
47 washing your hands, which is fine, but it's all part of the

1 deal, but it does create more stress because you've got
2 less time to do what you believe are the chores that you
3 need to do in your day-to-day.
4

5 Q. Have you seen any sort of settling of that stress
6 since the worst of those sorts of days seem to be behind
7 us?

8 A. Yeah, look, I think I have. Certainly this year, the
9 staff seem to be a bit more settled and you know, I would
10 say nurses are a resilient bunch or people who work in
11 hospitals are a resilient bunch and they just get in and
12 go, and they were stressed there through not being able to
13 fulfil each gap in the roster.
14

15 But that has eased at the minute because there's a lot
16 of agencies being presented to us, and through some
17 incentives and retention bonuses we've been able to attract
18 people to Lockhart, Hillston - all sites, through the
19 retention and attraction bonuses that have been thrown at
20 people who want to come to work for us, the overseas
21 recruitment.
22

23 Q. Before we go on to that, if I can ask you about the
24 bonus. So this is the regional workforce incentive
25 program; is that right?

26 A. Yes, that's right.
27

28 Q. How have you found that? Has it been effective in
29 helping to attract or retain people?

30 A. Yeah, I believe so. So Lake Cargelligo, for example,
31 have had three permanent - three permanent people apply and
32 take up positions. A couple of families, which is great
33 for our community. Hillston have attracted one. Lockhart
34 have attracted one. So that's - I think that has been
35 great and that's all within the last six months.
36

37 Q. And when you say they have attracted one, do you mean
38 a nurse?

39 A. I do. Sorry, my apologies.
40

41 Q. No, that's okay. Is the program open to other types
42 of staff - doctors, allied health, admin people?

43 A. That's a good question. I'll say I don't know the
44 answer to that.
45

46 Q. Sorry, I beg your pardon?

47 A. I don't know the answer to that.

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Q. That's fine. You mentioned also about overseas recruitment. Can you tell us a bit about that?

A. Yes, so the MLHD went overseas, went to Ireland last year to have a recruitment drive, and sent - an amount of staff, three or four staff, went over there to do an amount of interviews and try and attract and - registered nurses to our space, and I - my understanding is that we've attracted over 120 people. We've got 80 of them already on board as incoming. That has been great. They haven't all gone to all of my sites, but we're getting one to Lockhart and we're getting three to Leeton. They haven't arrived yet but it's exciting that they will in the near future.

Q. What other sorts of recruitment strategies do you use in terms of nurses? Are you participating in the central recruitment process, for example?

A. Yeah, so we - the way that we work recruitment is that we would look at our FTE and our staff establishment, and our staffing profile, to fill out a brief to the recruitment team that sit in the centralised space, saying we would like to advertise for a particular position, based on these numbers, you know, through our establishment.

Then they either agree or disagree and we pop it in through recruitment, through StaffLink, and advertise, and then the recruitment team take off and advertise. We could do short recruitment strategy or longer recruitment, so it goes to a broader span of advertising.

I don't have a lot to do with that space but I know at the moment we're working with a midwifery manager to, I guess, try and advertise in a different way to try and attract a midwife to Leeton, which has been difficult to do. So we're trying to do something a bit different.

Q. And how is it a bit different? What are you doing?

A. Well, I guess to spice it up a little, to put more information about the town, and more information about the position, so the attraction of the retention - that, to highlight those things, and the opportunity for professional growth and learning, to help develop their skills, which I think is one way forward, to develop our staff, to give them an attraction to come and work there because they're going to learn a lot more and their scope of practice will be at the top rather than in the middle.

1 Q. Who interviews them? Do they come to the town to be
2 interviewed or are they interviewed centrally?

3 A. No, well, they can - we would love them to come to the
4 town, but we do a lot of Teams interviews. Generally so -
5 generally speaking, depending on the role, I might get
6 involved as cluster manager, if it's a more senior role, so
7 we've been interviewing recently for facility managers and
8 nurse unit managers, and I'm involved in that. We're
9 looking for a particular type of person, I want to be - I'm
10 invested in helping grow our staff and pick the right
11 person for the right job.

12
13 If it's an AIN, EN, RN role, the site managers, the
14 nurse unit managers, the CNE would get involved and we have
15 to have an external person, so - I forget the term, but an
16 independent person, so it's not related to the hospital or
17 the cluster, and that might be someone from people and
18 culture, or it might be just someone we know, who we can
19 find, to come and get, that doesn't work in our cluster.

20
21 It would need to be specific, so we wouldn't have an
22 allied health member looking for a senior registered nurse
23 or - we try and pick the right people. We have some
24 guidelines in and around who actually attends to the
25 interviews.

26
27 Q. What about with the doctors? Do you have any
28 involvement in the appointment of the doctors?

29 A. Yeah, so the doctors are a little different. Yes,
30 I have been involved in those. But our doctors are
31 GP VMOs, so they really just sign a contract. They work as
32 a GP. If they have the credentials, they meet the
33 criteria, and if they want to come and work for us, they'll
34 meet with the DMS and they'll go through a separate process
35 and I'm not completely familiar with that.

36
37 Q. So when you say the "DMS", are you talking about
38 Professor Bruce, the district DMS, or are you talking about
39 hospital DMS positions?

40 A. I'm talking about the Griffith district medical
41 service manager, which would be Sunil Adusumilli.

42
43 Q. Do they assess the credentials to make sure the person
44 is an appropriate fit?

45 A. There's a medical workforce that sits separate to the
46 recruitment process and they are involved in that as well.

47

1 Q. And is it matched up with the sort of skill set that
2 you need in the facility?

3 A. Yeah, so the doctors have a different sort of acronym
4 or RCGVP - RVGCP or something similar. They have to have -
5 different levels of support may be required, so a level 1
6 doctor we wouldn't employ because they need too much
7 supervision; level 2 and 3 doctors, then level 4 would work
8 completely independently.

9

10 Q. So all of that's taken into account?

11 A. Yeah, absolutely. So dependent on what the doctors
12 are available in town, can they provide this service to
13 support a particular level of doctor.

14

15 Q. Going back to your example of the midwife that you're
16 trying to attract, just by way of example --

17 A. Mmm.

18

19 Q. -- if you identify someone who is a good fit for the
20 role and you're going to offer them the role, what do you
21 do or your team do to try and actually welcome them to the
22 location, settle them in and so on? What role do you have
23 in that?

24 A. So there's no guideline or principles. You don't have
25 to do anything in particular, you can offer them a job and
26 say, "Come on down." But for myself, I'm a big advocate,
27 and I know that Christine Stephens, our NAMO leader, has
28 talked about a concierge service, and that's exactly what
29 we try to provide. So you meet, greet, pick up, you know,
30 show them the town, so if you're employing - so recently
31 we've employed someone at Lake Cargelligo who has a wife,
32 it's a, you know, a male registered nurse, but he has
33 a wife and a child. So we've taken them to Lake
34 Cargelligo. We've taken them to introduce them to the
35 school. We've taken them down to the social clubs, and
36 those sorts of things. Support them in living, so like for
37 like accommodation, try to match suitable accommodation, so
38 for a family, they need to be independent, they need to be
39 in a home that's separate to, say, nursing accommodation,
40 that would be one bedroom for a shared bathroom, for
41 example. We couldn't do that to a family, it would be
42 unfair, so we try and match up that.

43

44 So previously I've picked people up from the airport
45 and taken them around town, and taken them to Wagga and
46 back out to Lockhart or showed them around. You might take
47 them to the Junee liquorice factory and try to entice them

1 into the country living, meet the school, clubs, that sort
2 of thing.

3
4 Q. Just having a look for a moment at some of the
5 retention strategies that you have for the existing staff,
6 I understand that you engage in some flexible rostering.
7 Can you outline what that involves?

8 A. Well, I guess it outlines just having a really strong
9 communication with each staff member, to - I get a gauge of
10 what's working well for them and what's not working well
11 for them and if there's any needs that they require.

12
13 So we have something called a TIRA, so a temporary
14 individual rostering agreement, where we can make
15 a short-term plan. So, for example, I've had one before,
16 because I played touch footy on a Monday night and I didn't
17 want to work Monday evening, so I'd go and see my manager
18 and I'd say, "Can I - I don't want to work Monday afternoon
19 because I play touch footy", we do a temporary rostering
20 agreement. We do it for a short time, because it's not all
21 year round, it's just 30 weeks a year. So the manager may
22 agree to that or may not, and it doesn't always suit and
23 not everything can be arranged perfectly.

24
25 But with return to work, in particular with mums
26 coming back, child care is difficult to get in all of our
27 sites, it's not an easy process, you have to book in well
28 in advance and you don't always get the days you want. So
29 if we have a mother come to us and say, "Listen, I can only
30 work Monday, Tuesday, Wednesday because these are the only
31 days I can get", we would do a temporary individual
32 rostering agreement to help meet those needs.

33
34 We do things like 5 till 10, a 5W under an agreement.
35 There is consultation with the union type space because
36 there are a number of rostering rules and guidelines that
37 we need to adhere to, but those conversations are in place,
38 and with the TIRA, we can sort of override some of those
39 difficulties as far as the union present.

40
41 Q. Has that made the difference in terms of some, say,
42 people being able to return from parental leave?

43 A. Yeah, absolutely, of course, yeah. So if we're able
44 to engage with - we've got two people back to the workforce
45 working part time at Narrandera, just recently. We've got
46 a number of TIRAs in at Leeton. In fact, all the sites
47 have a TIRA for one or two staff members, which is an

1 agreement, as I said, to get them back into the workforce
2 or keep them in the workforce for various reasons.

3
4 We've done one recently because they have
5 a deteriorating parent-in-law, so they want to be around
6 more regularly at home to help care for them, so they can't
7 work particular days because other family members have to
8 go to work or what have you.

9
10 Q. Are there challenges or disadvantages to the flexible
11 rostering?

12 A. Definitely challenges, because it is - the workforce
13 is small. So if we have a number of agreements, so, for
14 example, the Monday, Tuesday, Wednesday for child care -
15 a very large portion of our workforce are women, like many
16 of those have babies, so if they all - we have a number
17 going off at the same time, when they come back at the same
18 time, they might all want to work Monday, Tuesday,
19 Wednesday because that's how it works. So then other
20 registered nurses may never get a chance to work Monday,
21 Tuesday, Wednesday morning.

22
23 But I guess to override those difficulties it's about
24 communication, it's about really talking to the team and
25 getting them so that everybody can understand. Despite it
26 being an individual roster arrangement, so it's something
27 done between the manager and the one person, when I'm doing
28 it, if there's difficulties, I would say, "Are you okay for
29 me to share this information because this is going to be
30 hard for us to manage?"

31
32 Q. What other things do you do to try to create
33 a positive culture at the different sites?

34 A. I mean, smile. That's an easy one. So the positive
35 culture for me is - so I'm big on empowering staff. So
36 empowering staff to be able to work to their top of their
37 scope of practice, both in skill, so capability and knowing
38 their role; certainly in understanding what their
39 expectations are from management, so that they can then be
40 accountable for the right things and know what is going to
41 be - what their role entails. But education, further their
42 training and skill, is one way I think we try really hard
43 to get the younger nurses in particular to stay focused on
44 what they are doing and engaged. I'm a firm believer that
45 if you've got engagement, you are happy to be at work,
46 you're going to have better outcomes for our patients,
47 which is I guess what we're all there for.

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Q. What about things like safety huddles and sharing of safety, patient safety data?

A. Yeah, so, you know, there are a number of strategies within each hospital. So we do safety huddles of a morning and an afternoon, so - and I know --

Q. Can you just explain what a safety huddle is?

A. A safety huddle would just be, you know, everybody in the room sits down and chats quickly about what is working well and what isn't working well; where are our risks for that day or that moment; you know, what the future looks like. So we talk about the afternoon, the night, the next morning, so the roster is filled, we're right here. No-one has called in sick. "Room 11 is unwell, they are a risk, they are a high falls risk, they are getting unwell. We have got the doctor to come and do that." We talk about the things that need to be done. So, for example, if overnight was busy and we didn't get to check our resus bay, we would highlight that at that point and say it needs to be done, it hasn't been done yet. It's all the - it's patient safety, it's quality stuff.

Leader rounding is another, I think, a pertinent thing, so it is you and me connecting for a 15-minute chat once a month. To me, it improves engagement. I have open ears, I just write down some things and we have an action out of that. I think it works well because I also start with, you know, "This isn't working well for our space at the moment, we've had multiple falls, we're going to concentrate on making sure we get this stuff done, so we have better documentation. What is working well for you? What isn't? Is there anything that needs fixing? What can I do for you?", and you get an action. Again, I believe that might have come out of the "People Matter" survey some years ago: it's about connecting with your staff members so that everybody can feel engaged, feel empowered and involved in the outcomes of the day-to-day runnings of the hospital.

We do monthly accountability meetings, so again I do that with all our facility managers once a month. I'm asking them to provide certain data, so clinical data, certainly revenue - so we're talking a lot about that at the moment in regard to, you know, leave liability, expenses, overtime, all that sort of stuff. So that is a - probably that's an hour meeting, really engaging. It can

1 be quite fun, it can be quite stressful, but it's - yeah,
2 I really enjoy doing those things.

3
4 Q. Do you have staff doing quality audits to monitor --
5 A. Absolutely, so we have a QARS system, a quality
6 system, and each month there is a certain amount of audits
7 that you need to do and complete and to maintain, and then
8 the data from that would allow you to provide an action
9 plan to work with the CNE, then, to talk with the staff
10 about - so falls, for example. "April Falls" month is
11 coming up so it is big on our radar at the moment. So it
12 is a whole month where if somebody falls, we've got a
13 follow-up process, a policy and a procedure, sepsis
14 pathways and cone pathways, all sorts of things, and we
15 take the data out of that and talk to our team. So it is
16 one thing to do the audit and collect the data; the next
17 step is to govern the process so that staff are aware of
18 the outcomes or the actions required for us to meet the KPI
19 or the percentage that they are asking us to do.

20
21 Q. And do you find that that engages staff and gets them
22 into a team trying to resolve those sorts of risks?
23 A. Yeah, it can, and I guess it's how you talk about it.
24 Some people might take it as like a, "We're not meeting the
25 criteria and it is your fault", but that's hopefully not
26 how it is taken, it is there to deliver outcomes, and what
27 we haven't done last month we can improve on this month and
28 always striving to improve on what we are doing.

29
30 Q. I'd like to move on to talk about premium labour, by
31 which I mean nurses engaged through agencies and locum
32 doctors?

33 A. Yes.

34
35 Q. The previous witness, Mr Lawrence, stated that there
36 was a significant increase in the use of agency staff that
37 seemed to date from November/December 2022, and I was just
38 wondering firstly about your thoughts on why that might be,
39 sort of post that initial COVID spike?

40 A. Yeah, so I think the dates are about right. When he
41 said it, I did hear him say that, and I was
42 thinking August. I was a facility manager of Lockhart at
43 that point, and previous to that I would do very few hours
44 clinical and very few hours of overtime, and not to suggest
45 I didn't just work 40 hours, I just didn't claim it.

46
47 From about August, I started working more clinically.

1 In my opinion, as I mentioned earlier, that would be the
2 international agency type staff just stopped coming, they
3 weren't allowed to go through the borders and the guys,
4 I think that, were already here, their visa had run out and
5 they were leaving. Nursing I think - I don't think looked
6 to be an attractive space to go to at that point in
7 Mr COVID. We certainly had a few staff members that we
8 lost through the COVID space, where they had family at home
9 who were sick or going through a cancer diagnosis and
10 bringing COVID home. We had multiple conversations with
11 staff who were going through that so they either wanted to
12 work less or didn't want to work or took leave through that
13 period. And they are personal experiences that I had so
14 I could say that that would be accurate, in conversation.
15 Does that answer your question?
16

17 Q. It does. Just following on from that, did you find
18 that any nurses took early retirement or left nursing
19 because of their experience through the pandemic?

20 A. I had experience with several of that, and it was just
21 one of those things, I guess. It was almost time, and
22 I think, per the earlier conversation, I think the pandemic
23 sped up an ageing workforce because they could see, well,
24 do I really want to work in this space right now in these
25 conditions, where I could retire and go about my business?
26 So I think that there is truth in that.
27

28 Q. To what extent now, currently, are your facilities
29 reliant on agency nursing staff?

30 A. So three of the sites, and I did mention the busier
31 sites, Leeton, Narrandera and Lake Cargelligo are very
32 dependent on agency staff. Hillston have been very -
33 I won't say lucky. The previous manager - and we've just
34 employed a new one there, which has been great - the
35 previous manager did an excellent concierge service and she
36 did an excellent job of maintaining skill but upgrading
37 skill, and excellent rostering practices, to allow for
38 young people to come there and grow, and they have done
39 that, and so I - she did a fantastic job in that.
40

41 Lockhart do a similar job in that, and I was there for
42 five years previously, and the manager that took over from
43 me has done something similar of the same ilk, that
44 concierge type service, and they have agency. And they
45 recruited two people from overseas last year and they just
46 stayed the year. The town wasn't for them and they have
47 moved on, and that happens. So at the moment - well, they

1 were fully recruited until six weeks ago and then for the
2 last six or eight weeks they have been using agency staff
3 again, but for many years they didn't.
4

5 Q. Do you need to use agency allied health staff at all?

6 A. Very hard to find. So it has been used but it's
7 not a - in my cluster it is certainly not a common theme
8 or common - it is not common practice.
9

10 Q. Now, taking on board what you said before about it
11 being primarily a GP VMO model for medical care, do you
12 have a need for locum doctors from time to time?

13 A. So we do, yes. So Leeton is a locum service and the
14 ED is run by a locum, and they are all booked up in advance
15 for months and months and months and we have got the roster
16 almost done to the end of the year.
17

18 Q. Are they emergency specialists?

19 A. They are. So they cover the emergency department.
20 They also look after the acute patients - not all acute
21 patients, but some. So in Leeton it is a bit of a hybrid
22 breed with GP VMO who admit people and then they see them
23 on a daily basis while they are in hospital. We also have
24 sort of a front-door admission via ED, or back-door
25 admission via ED, and the locum doctor would treat and see
26 those people on the ward when they are admitted. All the
27 other sites are GP VMO, and all other sites have used
28 a locum to cover periods of absenteeism of the GP VMO, and
29 that is a planned process and it is supported by what is -
30 often supported by COAG 19 funding, which is a Commonwealth
31 scheme to help the primary health care space, and we raise
32 that money via the ED by completing particular forms, and a
33 particular treatment in ED is allocated a funding amount.
34

35 Q. Does that work well, you can find the doctors to fill
36 those slots to cover leave and so on?

37 A. Oh, not always, no. But for the most part, yeah,
38 because we pay them really well. So it is very attractive.
39 I mean, for a nurse, it's very attractive. They get paid
40 handsomely.
41

42 Q. Where do they come from generally? Are they from
43 metropolitan areas or other parts --

44 A. All over. Yeah. No one space. They are Queensland,
45 New South Wales, Victoria, South Australia. They often
46 already work somewhere and they are just want to do some
47 extra work. Yeah.

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Q. Going back to the nursing agency staff, is there any scope to have a casual pool that can try to support some of the bigger services in particular?

A. Yeah, so most sites have a casual nurse, but that casual nurse would generally work somewhere else as well, and so the genuine sense of what casual nursing or casual employment would be is they are not always available, because they are working somewhere else as well.

Leeton/Narrandera have a couple of different casual nurses, but again, they don't want full-time work, they want just to fill in gaps here and there and just remain employed.

Again, the casual gets a little bit extra incentive for - per hour, but not much. Yeah, we would love to, it's just where do you find them? We can't find permanent employees. Registered nurses in particular aren't living where we are.

Q. When you do need agency nurses, what process do you have to go through to get them?

A. So again, it's a brief to - through ROB, which is our IT system. It is written by what is a CSO, so a cluster CSO, an administration person.

Q. Can I pause you there for a second. We've had two acronyms in one sentence. So ROB stands for?

A. Recruitment Onboarding. Yep, sorry.

Q. That's okay, and CSO?

A. CSO is - I actually don't know. So it is an administrative officer.

Q. It is an administrative role?

A. Service officer. I should know. Sorry.

Q. That's okay. So go on. So the CSO puts the brief into ROB?

A. Yes, so I will collect the data through StaffLink and work out what our staff establishment is and where is the vacancy available, and, you know, we've got four nurses and we need eight. We put a brief in. I sign it. It goes to the general manager and then goes to our people and culture or our HR department and they will just have a quick look on it, they agree to it, sign it off, and then we pop it in

1 to recruitment who get the recruitment drive, and they
2 speak to the agencies.
3
4 Q. So before we get to there, so it goes from you to the
5 general manager of what?
6 A. Operations.
7
8 Q. Operations?
9 A. Of operations, yes.
10
11 Q. And then to people and culture, which is the old human
12 resources?
13 A. Yes, I said people and culture, I will take that back,
14 so it is actually through HR, our human resource team.
15 I just got confused there.
16
17 Q. Is that the same sort of process that's followed for
18 a locum doctor?
19 A. Very similar. The DMS would be involved in that, so
20 for me, it would be discussing it with Sunil to ensure that
21 we have a leave application, or the GP VMO would say, "I'm
22 not here for April", and we would have to put --
23
24 Q. And the person you mentioned then, is that the
25 director of medical services for one of the facilities?
26 A. Sunil, for our area.
27
28 Q. For your area?
29 A. I will say east and west. So there is one this side
30 and one that side, and Sunil looks after Griffith and
31 Leeton/Narrandera and the other four sites or three
32 sites --
33
34 Q. It sounds like there is a few steps, then, before you
35 actually get one from the agency.
36 A. Mmm.
37
38 Q. We heard from the previous witness that the governance
39 around use of premium labour had been strengthened, what
40 changes have occurred from your perspective, in terms of
41 what you need to go through to get an agency nurse?
42 A. Well, those steps that I mentioned are now in place.
43 They weren't always in place.
44
45 Q. They weren't always in place. So how long have they
46 been in place?
47 A. I think the whole time I've been in this role and had

1 previous acting positions, it wouldn't go to the HR person.
2 The operations manager would be involved.

3

4 Q. Do you ever encounter delays in being able to get an
5 agency staff member?

6 A. I'll say yeah, but they are minor. Delays as in days.
7 But I'd like to think we're well prepped and we're not
8 doing it last minute, we're planning for six, eight, 10, 12
9 weeks in advance. Rosters need to be printed six weeks in
10 advance, so we're looking well ahead. So, yeah, there are
11 some small delays, but that's - you know, I sign it, it
12 goes to someone else, sits in their inbox, then they have
13 to open it up and sign it and then it goes to the next
14 person, and so on. So there is a delay, but I believe it
15 to be minor.

16

17 Q. That's understandable if you are sort of six weeks
18 out. What happens if somebody is unwell and they are going
19 to be unavailable for a matter of a week?

20 A. So depending on the brief, the brief can stand for not
21 just that one agency, we might be asking for three, so it
22 sort of counter balances.

23

24 Q. Maybe if I put the question in another way, is there
25 a mechanism by which you can get urgent approval for an
26 agency person when you really need someone immediately?

27 A. I will say yeah, yeah. So I would speak to my - the
28 general manager of rural ops, Tegan, and we would have
29 a chat and say, "Someone has left, we've got short notice
30 absenteeism for a broken leg", or whatever it be, sick
31 leave, and it can be approved.

32

33 Q. Do you have any sort of say in which agencies are used
34 to source staff?

35 A. Not really. I could be involved and say, "We've had
36 poor experiences with this agency". We are heavily reliant
37 on the timeliness of the agency providing certain
38 documentation for OASV and clinical skill and resumes and
39 all that sort of stuff that goes with recruitment. If they
40 are slack, I would often say, "These guys don't do a great
41 job; is there any way we can go somewhere else?" But, to
42 be honest, we're looking at the skill of the person being
43 presented rather than the skill of the agency, if that
44 would make sense.

45

46 Q. Is it sometimes hard to find people who have the right
47 skill set for the range of what you need?

1 A. Yes, more than sometimes hard, yes.
2
3 Q. What sort of difficulties are there?
4 A. Well, finding someone who has an ED skill, an
5 in-charge role - they are not presenting. We can find
6 nurses often, but to find the person with the right skill
7 that has five years' experience, able to triage, able to do
8 advanced life support, able to work independently, without
9 a doctor, understand telehealth, understand EMR, have those
10 capabilities to learn quickly - that is not easy.
11
12 Q. And is part of your responsibility as the cluster
13 manager, for the financial side of things, do you need to
14 monitor the costs that are being spent on agency or is that
15 a central issue?
16 A. We monitor it because we have a budget at each site
17 and - but I guess we also have to provide clinical
18 expertise or a skill set to keep the space open. So, yeah,
19 we look at it and if we have an option, we'll choose the
20 option that may be more beneficial financially, but that's
21 not always the case. So yes and no.
22
23 Q. I gather accommodation is challenging, from what a lot
24 of people have told us. Is that an issue at all the sites
25 in your cluster?
26 A. Yes, it is.
27
28 Q. Are some worse than others?
29 A. Yes. That would be accurate.
30
31 Q. Can you explain a little bit further?
32 A. I think old school nursing accommodation is 25 rooms
33 that are just a single bed, maybe a basin, a shared
34 bathroom, two kitchens, and that's just how it was.
35 People's expectations today are a little different. So
36 they don't always want to live like that. People will
37 travel - and I have had to giggle a few times, they'll be
38 travelling with a horse or a parrot, so they need - they
39 couldn't live there because they need independent
40 accommodation. So we try really hard, so that concierge
41 type service, and we have now started private use of
42 housing. Not all sites - so Lockhart actually has a house
43 next door, which is owned by the MLHD, that's
44 a five-bedroom house. Fantastic house. It's not new, but
45 it's well cared for and looked after, it's upgraded and
46 maintained very nicely. But if you have five nurses in a
47 house working shiftwork, different days, different days

1 off, you will find, in my opinion, there is often
2 complications. Difficulty of men and women working and
3 living in the same space is often difficult as well, so we
4 do try to separate men and women, and so we've had to
5 employ - well, employ or engage with the local real estates
6 in Lockhart now to have staff. If you are doing
7 a recruitment and retention and you employ a family, and we
8 did, we had to then rent another house, because we've got
9 two nurses for - out of the family, a husband and wife
10 team, with two kids, so we couldn't put them in - that type
11 of accommodation wouldn't suit, so we get that housing.
12 The new gentleman that's started at Lake is a husband, has
13 a wife and a child. We've had to engage a house, and part
14 of that recruitment retention is they get accommodation for
15 a period of time. We just don't have the accommodation
16 available that's owned by MLHD or is on site or suitable.
17

18 Q. Just one other question. We saw some accommodation
19 pods last week at Tumut. I understand something similar is
20 being built in a couple off your sites?

21 A. Yeah, so Leeton and Narrandera, our district sites,
22 are getting three pods each. My understanding is that
23 Leeton will be finished by the end of the year and
24 Narrandera will be finished by February next year, '25.
25 They are fabulous. I mean, I've been to Hay, similar pod,
26 and the Tumut ones. Anyone could move in there. They are
27 just really well put together and they are on site, which
28 again - so agency staff often don't drive in, they fly in,
29 so the housing - we talk about accommodation. It is
30 difficult to have a house 5 kilometres away when they work
31 until 11 o'clock at night or start at 7 o'clock in the
32 morning. It needs to be safe, it needs to be appropriate.
33 So those pods are a great initiative. I'm not exactly sure
34 where the money has come from, where it has come out of
35 Kevin's budget with the MLHD or it has come out of
36 a different pocket of funding through that accommodation
37 initiative but, yes, they are going to be great for us.
38

39 Narrandera, just to add also, has tapped into some
40 COAG funding and they are redoing the current nursing
41 quarters. So we're adding a better service. So we will
42 have ensuite rooms, some rooms are a little bigger, some
43 rooms have - there is a couple of extra kitchens, more
44 bathrooms, more private bathrooms, et cetera, et cetera, so
45 that's really great.
46

47 DR WATERHOUSE: Commissioner, I have no further questions

1 I'm aware of the time.

2

3 MR CHIU: I have no questions.

4

5 THE COMMISSIONER: Sir, thank you very much for coming,
6 very grateful for your time. You are excused.

7

8 <THE WITNESS WITHDREW

9

10 THE COMMISSIONER: All right. Is there anything further
11 today? It is 10 o'clock, now, tomorrow. All right. We
12 will adjourn until 10 tomorrow, thanks.

13

14 **AT 4.05PM THE COMMISSION OF INQUIRY WAS ADJOURNED TO**
15 **THURSDAY, 21 MARCH 2024 AT 10AM**

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