

**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**

**Friday, 22 March 2024 at 10.00am**

**(Day 015)**

<b>Mr Ed Muston SC</b>	<b>(Senior Counsel Assisting)</b>
<b>Mr Ross Glover</b>	<b>(Counsel Assisting)</b>
<b>Dr Tamsin Waterhouse</b>	<b>(Counsel Assisting)</b>

**Also present:**

**Mr Hilbert Chiu with Mr Christopher Chiam for NSW Health**

1 <LENERT DESMOND BRUCE, on former affirmation: [10am]

2

3 THE COMMISSIONER: Good morning.

4

5 MR GLOVER: We will continue with Professor Bruce.

6

7 THE COMMISSIONER: Just come forward, sir, and have your  
8 seat again. We're going to put you over there, Professor,  
9 because you will get sunburn in this seat.

10

11 <EXAMINATION BY MR GLOVER CONTINUING:

12

13 MR GLOVER: Q. Professor Bruce, yesterday afternoon,  
14 before we adjourned, I asked you some questions relating to  
15 the treatment of public patients in private facilities as  
16 part of reducing the backlog, if I can put it that way. Do  
17 you remember that evidence?

18

A. That's correct, yes.

19

20 Q. I asked you whether there was a process to determine  
21 the patients which would form part of that approach, and  
22 you described how the clinicians would prioritise cases.  
23 Do you remember that?

24

A. That's correct, yes.

25

26 Q. Is there anyone else involved in determining the cases  
27 which would go to be treated in those private facilities  
28 under that arrangement?

29

A. We do have a district surgical services lead that  
30 oversees our sites where we do surgery and she would have  
31 a look at the wait list, clinical priority of patients. We  
32 look at the time available in particular lists, the length  
33 of procedures, to try and maximise the utilisation of our  
34 theatre capacity.

35

36 Q. And what about the determination of which cases go to  
37 which of the facilities that the LHD has an arrangement  
38 with?

39

A. In the end, for us, different facilities offer  
40 different services, and part of it is also if a surgeon  
41 already has a list at a particular facility, we can  
42 actually use - we use unutilised private capacity. So  
43 let's say a surgeon has a private list at a particular  
44 facility and there's capacity on that list, we can actually  
45 use that time and put some public patients on that.

46

47 Q. The surgeon in that case would be the surgeon who

1 would have the patient in the public facility, if there was  
2 capacity?

3 A. In most cases, yes. There are some cases, for  
4 instance, if surgeons are unwell, that we can actually move  
5 patients between different surgeons.

6  
7 Q. Are there any overarching policies which apply to  
8 these decisions?

9 A. There is a New South Wales wait list health policy  
10 that manages it, but for us, it really is just the patient  
11 is at the centre of what we do, and obviously we try to be  
12 as financially responsible as we can be.

13  
14 Q. When public patients are treated in private facilities  
15 under these arrangements, are there any increased costs to  
16 the state system in doing so?

17 A. At times, yes. So as part of the wait list  
18 arrangement last year, there was an agreed rate, but  
19 I would probably need to check with our team if there's any  
20 commercial in confidence information about what the  
21 particular rates are. But it can be more expensive at  
22 times, yes.

23  
24 Q. When you refer to the "arrangement last year", that  
25 was a push to reduce wait lists across the state; is that  
26 what you're referring to?

27 A. That's correct. Patients that were delayed as part of  
28 the COVID pandemic, so we did receive additional funding to  
29 make sure that those patients got treated as soon as was  
30 practicably possible.

31  
32 Q. What about going forward? Do you see or perceive the  
33 need for this type of approach to continue?

34 A. From our point of view, we would try and do as much as  
35 we can in-house, but as discussed previously, there are  
36 challenges with specialised nursing workforce, so  
37 perioperative nursing staff, medical staff at times, so  
38 there may still be a need for some utilisation of private  
39 capacity while we build our own.

40  
41 Q. In that context, the utilisation of the private  
42 capacity is because those are procedures that may not be  
43 able to be performed within the facilities in the district;  
44 is that what you're referring to?

45 A. Some of them cannot, that is correct, yes.

46  
47 Q. Do you have your outline there, Professor Bruce?

- 1 A. I do, yes.  
2  
3 Q. If I can take you to paragraph 7?  
4 A. Yes.  
5  
6 Q. Paragraph 7 to 13, you address the topic of premium  
7 labour?  
8 A. That's correct.  
9  
10 Q. Do you see that?  
11 A. Yeah.  
12  
13 Q. Premium labour is locums and agency nursing staff; is  
14 that right?  
15 A. That's correct.  
16  
17 Q. Does it include any other categories?  
18 A. We do occasionally use premium labour in allied  
19 health, but probably the most common would be medical and  
20 nursing.  
21  
22 Q. Has there been a trend of increased reliance, a need  
23 to rely on premium labour in the district?  
24 A. Probably one of the areas where there have been  
25 changes is in the district hospitals where previously, the  
26 utilisation of locum or premium locum medical staff would  
27 have been very rare. Unfortunately, it is something that  
28 is becoming more common and we are in positions where we  
29 have to utilise agency staff in our busy district  
30 hospitals, especially where you've got high volume  
31 emergency departments. That's probably the areas where  
32 we've seen increased utilisation.  
33  
34 Last year, as part of the surgical recovery program,  
35 we did need increased specialist anaesthetists to help us  
36 perform the additional surgery, and in terms of the  
37 emergency department, the specialist locums were probably  
38 reasonably stable because we have a certain number of FTE  
39 and there's some fluctuation in terms of the so-called  
40 mid-grade medical staff.  
41  
42 Q. In paragraph 12 of your outline you identify the ideal  
43 scenario where premium labour might need to be used, and  
44 that is to cover leave --  
45 A. That's correct.  
46  
47 Q. -- permanent staff? Has there been a shift within the

- 1 district to use premium labour more widely than what you  
2 strike as the ideal scenario?
- 3 A. Well, it's a sign of necessity. We would always try  
4 and, you know, use employed staff, our own team, not just  
5 because of the financial benefit but there are significant  
6 clinical care benefits in staff knowing their environment,  
7 understanding the clinical context, people working in a  
8 team where the team members are familiar with one another  
9 as well.
- 10
- 11 Q. That's why the ideal scenario is the ideal scenario;  
12 correct?
- 13 A. That's correct, yes.
- 14
- 15 Q. One way it's been put to the Commission is that  
16 premium labour, in your ideal scenario, would be a support  
17 to the system?
- 18 A. That's correct.
- 19
- 20 Q. But there have been trends in recent times where it is  
21 becoming an integral part of the system; would you agree  
22 with that?
- 23 A. Yes, unfortunately so.
- 24
- 25 Q. In paragraph 12 you tell us that some of the emergency  
26 departments within the district rely on premium labour to  
27 cover the emergency departments?
- 28 A. That's correct, yes.
- 29
- 30 Q. By that, do you mean that those emergency departments  
31 are staffed entirely by premium labour?
- 32 A. There would be, you know, from memory, I think  
33 probably one of our district hospitals that relies almost  
34 solely on premium labour. There would be other ones where  
35 we need premium labour as part of the rest of the team.  
36 But you would say that it's an integral part of the  
37 workforce.
- 38
- 39 Having said that, there is a benefit of having locums  
40 that return regularly, so at least, even though they, you  
41 know, incur premium cost, at least they're familiar with  
42 the facility and familiar with the staff.
- 43
- 44 Q. Apart from familiarity, are there any other benefits  
45 to the use of locum or agency staff that you see?
- 46 A. Well, there are benefits that we get exposed to  
47 clinicians with, you know, a broad range of experience and,

1 you know, for us, speaking as the previous director of  
2 anaesthetics, it's been a very valuable recruitment tool.

3  
4 We've had quite a significant number of doctors that  
5 came to us initially as locums and then decided, well, gee,  
6 it is a great place to work, and then they then, you know,  
7 become visiting medical officers. So there are benefits to  
8 it. I think the most important bit is how locum staff are  
9 utilised.

10  
11 Q. Aside from cost, which I will return to in a moment,  
12 are there any particular downsides to the increased use of  
13 premium labour within the district?

14 A. Well, there's obviously all the on costs - travel,  
15 accommodation. There's a risk of people cancelling. Every  
16 time we utilise a new locum, there is a component of risk  
17 because we've not met them before, you know, even though  
18 they are good and capable clinicians, they may not always  
19 be a fit for the particular area where they're going to  
20 work, so there definitely are some downsides to it. We  
21 obviously have to provide accommodation to them as well and  
22 that can be challenging, if you utilise large numbers of  
23 locums.

24  
25 Q. Are you familiar with the costs incurred by the  
26 district in engaging premium labour?

27 A. Yeah, I unfortunately don't have the exact number for  
28 that, for the whole district, unfortunately.

29  
30 Q. Are you aware whether the number has been increasing  
31 over recent times?

32 A. Well, from memory at Wagga Base the numbers have  
33 increased.

34  
35 Q. What about in other parts of the district?

36 A. There would be some of the smaller facilities where  
37 the numbers would have increased but I don't have exact  
38 numbers.

39  
40 Q. In paragraph 13 of the outline you tell us that the  
41 district is strategic in how locums are deployed?

42 A. That's correct.

43  
44 Q. What do you mean by "strategic"?

45 A. So for us, there's a threshold where we believe  
46 ideally you should have a doctor on site or available to  
47 attend if required, and those are the areas where we engage

1 locums. So if we have a low-volume emergency department,  
2 we would rather provide support for them through virtual  
3 care, which is our remote medical consultation service.  
4

5 The other things that we do, if we have locums in  
6 larger departments, there are clearly some shifts that  
7 incur penalty rates, and we, you know, would use locums in  
8 those sort of higher cost shifts, because we're already  
9 paying the premium cost, and then utilise our own staff in  
10 the - in different shift patterns.  
11

12 Q. In that answer you referred to a threshold. What is  
13 the threshold that you are referring to?

14 A. For us, if there's less than 10 presentations per day,  
15 we wouldn't really put a doctor in a particular site. That  
16 can go up because we also look at the acuity of  
17 presentations, so you could have an emergency department  
18 where there's 15 presentations but if 10 of those are low  
19 acuity presentations, like category 4 and 5, they can  
20 easily be managed through virtual care. So we look at  
21 numbers and also the acuity of the presentations.  
22

23 Q. Is part of the analysis in that strategic deployment  
24 of locums a comparison between what it would cost to staff  
25 it, with a locum, versus the cost of delivering the virtual  
26 care model?

27 A. We do look at cost but our first priority always is,  
28 you know, patient and staff safety. So we do consider  
29 finances but, in the end, you have a limited resource and  
30 what we need to work out is where is the best place to  
31 deploy that particular resource.  
32

33 Q. Just while we're on the virtual care model, has there  
34 been any analysis done on the effectiveness of that model  
35 in delivering the care into those EDs where it's deployed?

36 A. Well, I think what we need to look at is how do you  
37 define effectiveness? For me, firstly, you know, is the  
38 care safe? We have an incident monitoring system and to  
39 the best of my knowledge, there's no increased incidents in  
40 patients being cared for through virtual care.  
41

42 It does provide benefits where we can actually now  
43 admit patients to district hospitals through virtual care  
44 and they don't get transferred to the base hospitals, and  
45 there is actually very good levels of staff satisfaction,  
46 the nursing staff actually feel very comfortable. But from  
47 my understanding, there is actually a formal evaluation

1 under way of our remote medical consultation service but  
2 it's not completed yet.

3  
4 Q. And if I can just come back to the costs, not wishing  
5 to distract from the importance of the issues that you've  
6 raised, but have there been any analyses done on the cost  
7 to deliver the virtual care model within the district?

8 A. Well, we know what the costings of - because we use  
9 a third party provider, so then there definitely would be  
10 cost of exactly how much we're spending on it. I think  
11 that the benefit for us is that the rate of remuneration is  
12 competitive to what a normal medical officer would earn,  
13 but the benefit is they cover a large number of hospitals.  
14 So having virtual care technology you can have one doctor  
15 that covers five hospitals, where if you had to put  
16 a doctor in each of those hospitals, the volume probably  
17 wouldn't justify it and the cost would be significant.

18  
19 THE COMMISSIONER: Q. Professor, who is doing the formal  
20 evaluation of your remote medical consultation service? Is  
21 that internal or some external group or body doing it?

22 A. I would have to take that on notice, sorry. I don't  
23 know.

24  
25 MR GLOVER: Q. Do you have your outline --

26  
27 THE COMMISSIONER: The chief executive might, later.

28  
29 MR GLOVER: Q. Do you have your outline there,  
30 Professor?

31 A. Yes.

32  
33 Q. In paragraphs 14 and following you refer to some  
34 initiatives. Can I just take you to paragraph 14?

35 A. Yeah.

36  
37 Q. There you refer to opportunities to address the demand  
38 on services?

39 A. Yeah.

40  
41 Q. So yesterday, I raised with you whether the approach  
42 was, in my words, a two-pronged approach, one to reduce  
43 demand, one to increase supply as part of the approach to  
44 workforce challenges. Do you remember that?

45 A. Yes, that's correct.

46  
47 Q. Is what you're describing in paragraph 14 here the



1 opportunities that you see to influence the demand side of  
2 that equation?

3 A. That is correct, yes.

4  
5 Q. If we can start with 14(a), there you refer to  
6 investing in primary health care to improve the general  
7 health of the district community. Do you see that?

8 A. That's correct.

9  
10 Q. What do you have in mind as an opportunity for the  
11 district to invest in primary health care?

12 A. I think the primary health care, the way that I look  
13 at it, it really is preventative health care, and as we  
14 spoke yesterday, that there is a certain threshold for  
15 a general practice to be viable, but if we can combine that  
16 with hospital work, that can actually create an attractive  
17 proposition for a medical officer. That would be one.

18  
19 The other benefit is that the LHD can support primary  
20 care through multi-disciplinary teams, allied health, nurse  
21 practitioners, nursing staff, which actually deliver better  
22 outcomes for patients.

23  
24 The second component to improving primary care is  
25 actually to differentiate between what is emergency care  
26 and what is urgent care, and the big challenge that we've  
27 had is that that line has been blurred. We have very, very  
28 effective emergency departments to deal with emergencies,  
29 but a large proportion of the work that presents to the  
30 emergency departments is what we call urgent care or, in  
31 rural communities, actually primary care, and an emergency  
32 department is not a suitable environment to provide primary  
33 care - it's not designed for it; it's not staffed for it;  
34 and in a lot of cases, that is not the skill set of the  
35 medical officers that work there.

36  
37 THE COMMISSIONER: Q. It is not the purpose for it,  
38 obviously?

39 A. That is correct. And I think we see that, if we look  
40 at the performance of the Wagga Base emergency department,  
41 for category 1 and 2, the true emergencies, they perform  
42 extremely well, but then, as we move down through the  
43 triage category, the effectiveness of the service is  
44 actually not good, and what we did was to look at the  
45 models that are available overseas.

46  
47 There's a very, very strong urgent care service in

1 New Zealand, and they actually have a separate specialist  
2 college for urgent care, which is actually  
3 multidisciplinary and you have emergency physicians, rural  
4 generalists and general practitioners that work there.  
5 What is important is that urgent care and primary care is  
6 not the same.

7  
8 Primary care for me really is about chronic disease  
9 management. Urgent care is episodic acute care. But we've  
10 been lucky enough to establish an urgent care service as  
11 part of Wagga Base Hospital, which we call the rapid access  
12 clinic, and it actually has been very effective. In that  
13 calendar year of 2023, we had more than 2,000 patients that  
14 were actually referred from the emergency department. Then  
15 there was an additional 700 patients that required  
16 orthopaedic surgery that previously would have actually  
17 gone to the emergency department, that has now actually  
18 gone through the rapid access clinic.

19  
20 In terms of clearly we're constantly evaluating the  
21 quality of our service and if we look at more than  
22 95 per cent of patients that went to our rapid access  
23 clinic would actually rate their care as good or very good,  
24 so there's clearly high levels of patient satisfaction.

25  
26 It has also led to some financial savings and we  
27 project that for this financial year, there would be a cost  
28 saving of approximately \$1.8 million for the patients that  
29 are treated in the rapid access clinic versus the emergency  
30 department.

31  
32 Q. Can I just break up some of the concepts in that  
33 answer?

34 A. Sure.

35  
36 Q. The first you mentioned is that there was an  
37 opportunity to support general practice with hospital work.  
38 By that, do you mean providing opportunities for general  
39 practitioners to act as GP VMOs?

40 A. That's correct, yes.

41  
42 Q. The second is that you referred to the support through  
43 multidisciplinary teams?

44 A. Yes.

45  
46 Q. How can the district invest in that - further invest  
47 in that approach?

1 A. Well, so clearly for us, there'd be two components -  
2 on site allied health staff. We've got a strategy called  
3 the rural generalist nurse practitioner role, where we will  
4 engage additional nurse practitioners that actually have  
5 special skills to manage chronic disease, which will,  
6 firstly, improve our in-reach into communities, and it  
7 would also support the general practitioners and increase  
8 access for patients. We can actually increase that service  
9 through the utilisation of virtual care. We already have  
10 a reasonably well developed telehealth outreach service  
11 through our geriatric department and also through our  
12 paediatric team.

13

14 Q. So these are services that you perceive as being  
15 delivered in the community or in the facility, or both?

16 A. Well, it would be a combination. I think there are  
17 benefits of having a health hub in the community, which is  
18 the facility, especially because we've got access to very  
19 good telehealth facilities which may be better than what  
20 patients have access to at home, and I think it is very  
21 nice to have that health hub in a particular community.

22

23 Q. Are public outpatient clinics part of this process?

24 A. Most definitely. For us, probably that's one of the  
25 major areas of development, you know, especially at Wagga  
26 Base, and there has been, you know, some increase in the  
27 clinics that we provide. But obviously for us, it will  
28 take a significant period of time to develop, you know,  
29 a complete suite of services.

30

31 Q. What about for those communities in the district that  
32 are removed from Wagga Base? How are those facilities to  
33 be - how are those services to be delivered to those  
34 communities?

35 A. Well, there's definitely a role for telehealth,  
36 because it does increase the reach, you know, even though  
37 it is ideal for practitioners to outreach in person, travel  
38 time is down time, and if a doctor spends four hours in the  
39 car driving, they're not seeing patients in those four  
40 hours, so I think we really need to look at building  
41 capacity locally and having general practitioners with  
42 advanced skills so you can - what we call, co-consultation,  
43 where the patient will be with their GP in the community  
44 and the specialist will use technology to dial in and  
45 they'll essentially have a multidisciplinary discussion.

46

47 Q. So one of the advantages in that scenario of virtual

1 care is access to specialist care where there may not be  
2 a specialist on the ground; correct?

3 A. That's correct.

4

5 Q. Are there downsides, though, to the increase in use of  
6 virtual care?

7 A. I do think that there are benefits of interacting with  
8 a patient in person, and especially with particular  
9 conditions - you know, areas that come to mind are mental  
10 health, especially if a particular patient has not built up  
11 a therapeutic relationship with a practitioner. But once  
12 again, though, it's not uncommon for patients to have, you  
13 know, an historical face-to-face consult initially and then  
14 have follow-up through virtual care. So I think it's  
15 important that we just need to be adaptive and meet the  
16 needs of the patient.

17

18 Q. Is there a risk that an increased use of virtual care  
19 might further centralise specialist services in metro or  
20 larger centres like Wagga Wagga?

21 A. Well, clearly it can be, but that's why our role is to  
22 have a critical mass of staff locally and to build on our  
23 relationships with metro hospitals, where staff actually  
24 come down and visit. But once again, there are certain  
25 benefits through virtual care that we would never be able  
26 to meet. The classic example is the Teleburns service that  
27 we run out of the Wagga Base rapid access clinic, where  
28 patients are followed up in consultation with the  
29 specialist burns unit at Concord. It would be highly  
30 unlikely that we would ever have a specialised burns unit  
31 in Wagga, but it means that a patient from the Murrumbidgee  
32 will have the same access to sub-specialty care as someone  
33 in Sydney, which is great.

34

35 Q. What you are describing there is maintaining access  
36 for those communities whilst also fostering and maintaining  
37 a local capacity?

38 A. That's correct. And a big part of virtual care is  
39 actually building local capacity when they interact with  
40 our clinicians, we become more comfortable, and a lot of it  
41 is really about making sure that we extend the skills of  
42 the clinicians that we have.

43

44 Q. In paragraph 14(a) you refer to the New Zealand  
45 approach, and you've referred to it briefly in an earlier  
46 answer?

47 A. Yeah.

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Q. Can you just expand on the features of the New Zealand approach that you see as beneficial?

A. Yes, so in New Zealand, as I spoke before, they have a strong focus on urgent care and they have a clear divide between an emergency department and an urgent care service. And clearly for them, it's effective in terms of the number of patients that present to emergency departments. So --

THE COMMISSIONER: Q. Someone's just sent me those details while were you talking. I haven't done this myself, but New Zealand, and particularly Auckland obviously, where there's a lot of urgent care clinics, have far less presentations to EDs per 1,000 head of population than Australia.

A. That's correct. So clearly they're doing something right.

Q. And they, as you say, have an actual college for urgent care medicine?

A. Yeah, that's correct. So it is just a different model, and one of the areas that I think we need to be very clear on, that health expenditure is actually being driven where care is delivered. So the interface between the clinician and the patient drives cost. So if we want to be financially sustainable, that is the area that we need to address, exactly how we deliver care, because clinicians are absolutely passionate about providing good patient care. They're very engaged in that, and our role is to help them to make sure that that interface is as efficient as possible.

Having urgent care services where we have the right doctors and nurses providing the right level of care is really the way for us to go forward. It is a mistake to have a system that we believe is not the right fit and just pour more money into it.

MR GLOVER: Q. You mentioned in an earlier answer some analysis on the financial benefits of the rapid access clinic?

A. That's correct.

Q. Have you started to see some of the benefits in terms of ED presentations?

A. So what was initially evident in Wagga is that post the COVID pandemic, there were quite a number of facilities

1 where the number of presentations have actually - went back  
2 to pre-COVID levels and then actually overshot.

3  
4 In terms of Wagga Base, because of the way the system  
5 is currently designed, the patients still present to the  
6 emergency department and through the Australian system,  
7 they count it as a presentation, but we know that, you  
8 know, we have 2,000 or 3,000 patients that then were cared  
9 for somewhere else.

10  
11 In New Zealand, their data collection is different, so  
12 if you are only triaged in ED, you're not counted as an ED  
13 presentation, which is right because you don't receive care  
14 in the emergency department, and also if you're referred to  
15 a specialised service like a medical assessment unit, where  
16 you're not treated in the emergency department.

17  
18 Q. So the headline statistic may not reveal the true  
19 story, but do I take it from that you're confident that  
20 since the implementation of the rapid access clinic,  
21 there's more patients being treated in that context than  
22 would otherwise - that would previously have remained in  
23 the ED?

24 A. Well, they would have just stayed in the emergency  
25 department. Probably the easiest win we had were patients  
26 is that presented for non-elective orthopaedic surgery.  
27 Historically, they would have presented to the emergency  
28 department and then be admitted through that, which is not,  
29 you know, the role of the emergency department, and then in  
30 the last six months of last year, we had about 700 patients  
31 that went through our rapid access clinic service.

32  
33 Q. These are patients who may have broken a limb and  
34 require surgery?

35 A. That's correct. So let's say you break your arm, you  
36 present to ED, yes, you need an operation, you need to come  
37 back tomorrow or Sunday. Historically you would be told to  
38 re-present to the emergency department where you would  
39 require the resources of ED, the nursing staff, sometimes  
40 medical staff, those patients are now just - they present  
41 to the rapid access clinic and they really walk around the  
42 corner to the operating theatre.

43  
44 Q. Another of the opportunities to address the demand  
45 side of the equation that you identify is the expansion of  
46 scope of practice of other health care providers?

47 A. Most definitely. I think unfortunately in Australia

1 we have a very historical physician based model of care,  
2 which may seem appropriate but it's not. We really need to  
3 look at what services particular patients require and who  
4 are the best practitioners to deliver that. Nurse  
5 practitioners are very valuable. Paramedics are an  
6 extremely skilled workforce, especially in managing  
7 emergencies, and we already utilise them in our smaller  
8 facilities where we have a process called CERS assist,  
9 where if there's a critically ill patient in the emergency  
10 department, the paramedic actually comes and supports the  
11 GP and our staff. But there's definitely opportunities to  
12 do that.

13  
14 I think access to more allied health staff, I think  
15 especially in the area of mental health, having access to  
16 psychologists will be extremely valuable, and I think we  
17 need to look broader, because, in the end, it's about care  
18 to patients.

19  
20 Q. The concept of expansion of scope and permitting those  
21 practitioners to practise at the top of their scope --

22 A. That's correct.

23  
24 Q. -- is there scope to - "scope" isn't - again, I'll  
25 rephrase it. Are there opportunities to perhaps permit  
26 those practitioners not only to expand their scope but  
27 better practise at the top of their level?

28 A. Well, clearly training is an important component. The  
29 other bit is support and networking, where we can provide,  
30 you know, either virtual support or in-person support in  
31 the town to support other practitioners.

32  
33 Clearly for us, there are opportunities to expand that  
34 service, and one of the areas that we spoke about is the  
35 rural generalist nurse practitioners, and we also speak  
36 about role substitution, where, you know, is there another  
37 health care provider that can provide that particular level  
38 of care?

39  
40 Q. Is there anything the system could do to harness those  
41 opportunities better?

42 A. I think having model scopes always helps us, from  
43 a credentialing point of view, if there's a statewide, you  
44 know, model scope for particular clinicians, which there  
45 already is for some of the nurse practitioner roles. Not  
46 necessarily from a state system, but from a federal system,  
47 there are certain funding implications, depending on who

1 provides the services, so I think it's important that, in  
2 the end, the care should be funded based on what is  
3 delivered not necessarily on who delivers it. So there  
4 would be, you know, particular services for which a nurse  
5 practitioner cannot claim, but a general practitioner can  
6 claim.

7  
8 Now, I think if the nurse practitioner can provide the  
9 service, the funding should be for the service, not, you  
10 know, for the practitioner who delivers it.

11  
12 Q. Do you perceive there to be any resistance within the  
13 system to expansion of scope of practice by some of the  
14 practitioners that you've referred to in your evidence?

15 A. There may be. Clearly there's always a concern of  
16 different craft groups encroaching on one another's, you  
17 know, patch, for lack of a better word, but in the end,  
18 that is just change management that we need to go through.

19  
20 You know, from our experience, the vast majority of  
21 our nurse practitioners are very highly regarded and are  
22 well respected. I think areas where there are concerns  
23 would be things like nurse endoscopists, which are  
24 available abroad, very limited here, and clearly as an  
25 anaesthetist, one of the areas that has been raised locally  
26 is the concept of nurse anaesthetists, which obviously are  
27 available in America and also in New Zealand. But once  
28 again, you know, I think we need to accept that we're  
29 a multidisciplinary team and there's a role for all of us.

30  
31 Q. Is there something that the system itself could do to  
32 perhaps facilitate that discussion to overcome some of  
33 those barriers?

34 A. Yeah, I think, you know, early clinician engagement  
35 with different professional bodies is important right at  
36 the start, and I think for us it's about how we work  
37 effectively together. But it would have to be part of it  
38 that, you know, nurse anaesthetists would not work  
39 completely independently from, you know, physician  
40 anaesthetists. There is an interaction and a synergy,  
41 similar for, you know, nurse endoscopists, so I don't see  
42 that as an insurmountable problem.

43  
44 Q. However it may ultimately be structured, do I take it  
45 that you see those practitioners operating to the top of  
46 the scope of their practice --

47 A. That's correct.



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Q. -- or an expansion in their scope of practice as being of critical importance to managing the workforce challenges?

A. Yeah, most definitely. I think it is better to broaden our base of providers than to focus on one particular group.

Q. In paragraph 14(c) you identify as another opportunity to address the demand side of the equation as being the alignment of medical officer utilisation to consumer health needs.

A. Mmm-hmm.

Q. By that, are you referring to the planning of how medical officers are deployed --

A. That's correct.

Q. -- within your district to meet the particular needs of the population in the area?

A. Yeah, and it also is about what services we provide. There's been a number of witnesses that spoke about the burden of chronic disease, and maybe we should be less focused on emergency departments and more focused on, you know, good chronic disease management.

That is an important part of our engagement with communities, because the healthcare facility is a large part of the identity of the community. There is a perceived security of an emergency department with a medical officer, but if 80 per cent of the population really needs very good management of their diabetes, heart failure, COPD, that is really their greatest need, and that will be the greatest benefit for them, because one of the problems that we have in health care is we have a lot of volume based data, because it's easy to count, but we don't necessarily have good ways to measure the outcome, because we measure the number of operations we do within the time that we do, and we have reasonably crude measurements of hospital acquired complications.

But I've never seen a publication that actually mentions healthy days at home or, you know, for patients to be able to do things they want to do, and I think we need to look at that, and that must be the basis of what we're trying to improve for patients.

1 Q. What do you see as the state health system's role in  
2 the management of those chronic conditions in the  
3 community?

4 A. Well, we have a very important part or role because  
5 those are the needs of the community that we serve. We  
6 work for that population of the Murrumbidgee, and we need  
7 to look after them. So we have a very important role to do  
8 that, and if we look at strategies that work effectively,  
9 so the collaborative commissioning would be one example,  
10 MRGTP, those strategies are areas where the federal and  
11 state funding is actually pooled, and while we have the  
12 separate funding models, it will be very, very difficult to  
13 have integrated services.

14  
15 And remember, the patient is just unwell. They don't  
16 understand state, federal, different funding models and we  
17 just make it too complex. Even for health care providers,  
18 the system is too complex.

19  
20 If you look at mental health, the number of different  
21 providers in the Murrumbidgee providing mental health is  
22 very, very difficult for patients to navigate the system,  
23 and everybody is very, very engaged and committed to the  
24 community, but the service is just too fragmented.

25  
26 Q. Is the concept you're referring to there the need to  
27 deliver the care where it's needed when it's needed,  
28 irrespective of who funds it?

29 A. That's correct. Well, in the end, Australia funds it.  
30 Whether or not it comes from either the state or the  
31 federal government it doesn't matter; the Australian  
32 taxpayer is funding it. I think one of the benefits that  
33 New Zealand does have is that primary care is in the remit  
34 of the district, it's not completely separate, and as soon  
35 as different structures are separate, with their own KPIs,  
36 their own performance, it becomes challenging.

37  
38 Q. In paragraph 17 and following of the outline you refer  
39 to the opportunities to increase the supply of the  
40 workforce?

41 A. Yeah.

42  
43 Q. And in paragraph 18 you identify the need to attract  
44 medical students by expanding the training beyond large  
45 hospitals?

46 A. Yes.

47

1 Q. And in about the third line down, you say:

2

3 *As a result of the current structures there*  
4 *is less awareness of the opportunities*  
5 *available to provide care outside the*  
6 *hospital context.*

7

8 A. Yes, yeah.

9

10 Q. What is the issue that you are referring to there?

11 A. Historically, medical students are trained in large  
12 tertiary facilities, so the only care that you ever see are  
13 the patients that are in hospital. You don't see that vast  
14 group of patients that are actually never admitted. So we  
15 have improved that by having some rotations into general  
16 practice, but it's still a fraction of training.

17

18 Then, even when students go to general practice, they  
19 don't necessarily have exposure to, you know, district  
20 hospitals' MPS sites, and a lot of them won't have any  
21 exposure to something like "Hospital in the Home."

22

23 So in my role as the head of campus for CSU in Wagga,  
24 we actually made a concerted effort for our students to  
25 actually go with the "Hospital in the Home" team and  
26 actually experience what care can be provided at home,  
27 because, in the end, you only know what you know. If  
28 you've never seen a patient being managed at home, the  
29 chance that you will choose that for a course of treatment  
30 for your patient once you're a trained specialist is very,  
31 very small.

32

33 It was quite fascinating feedback from the students,  
34 the areas that they enjoyed the most was the "Hospital in  
35 the Home" service, and the other area was the outpatient  
36 flow unit where they coordinate the virtual care. They  
37 absolutely loved it, to see what can be done in peripheral  
38 hospitals.

39

40 Q. That's the benefit of the rural clinical schools?

41 A. That is correct, but also the model and the program  
42 that you deliver, because Wagga Base is really a tertiary  
43 referral hospital and if the students only train in Wagga  
44 Base, they would be missing out.

45

46 Q. In paragraph 19 you refer to the centralised model of  
47 junior medical officer recruitment?

1 A. That's correct, yes.

2

3 Q. Please describe that model?

4 A. Yeah, so in New South Wales, JMO allocation is managed  
5 by HETI, which is the Health Education and Training  
6 Institute. There would be processes of what we call the  
7 rural preferential recruitment, where junior doctors who  
8 would like to work in rural areas apply, and there's an  
9 interview process and then there's a computerised matching  
10 system in terms of how you scored and what your preferences  
11 are, and then the junior doctors are allocated.

12

13 Now, the benefits of the centralised system, it means  
14 that junior doctors are distributed through the system,  
15 which is a good thing, it means that, you know, you won't  
16 have a hospital that doesn't have any interns. But the  
17 challenge that we've had is that we've actually had medical  
18 students that, you know, spend most of their medical  
19 training in Wagga, but because they were overseas medical  
20 graduates, you know, there's a different sort of level for  
21 them in the matching system that, even though they want to  
22 stay on in Wagga and we have a vacancy, they're not  
23 necessarily allocated to a position here.

24

25 Now, having said that, we actually, for one of the  
26 particular students, did put a special request in and that  
27 junior doctor was allocated. But it is challenging when we  
28 have junior doctors who want to work rurally and in an area  
29 where they have, you know, built relationships, their  
30 partner may have a role, their kids may be in school, and  
31 they're then sent off somewhere else.

32

33 Q. So do you perceive then there needs to be more  
34 flexibility in the model to cater for those need?

35 A. Most definitely. You know, we - there's benefits to  
36 the centralised system but we need to be sensible in terms  
37 of accommodating students who want to be here.

38

39 Q. In paragraph 21 you identify some strategies that  
40 could be adopted to increase the number of doctors who  
41 undertake their specialist training in the district or  
42 other rural areas; do you see that?

43 A. Yes.

44

45 Q. And in 21(a) you identify that one of those strategies  
46 may be that training positions should be specifically  
47 allocated to rural areas for specialised training and then

1 to rotate to metropolitan areas to undertake training in  
2 fields where that training is not available?

3 A. That's correct.

4  
5 Q. How does that differ from the current model?

6 A. Well, in the current model, the vast number of  
7 training positions are in metro hospitals, and the trainees  
8 will come and rotate to us for three to six months, but in  
9 the end, they spend the bulk of their training in the metro  
10 hospital.

11  
12 Where it does become challenging, especially in the  
13 field of anaesthetics, is that there are certain areas that  
14 you require as part of your training program, like  
15 cardiothoracics and neurosurgery, which we obviously don't  
16 do at Wagga Base, and then for our trainees to get access  
17 to those skills can be difficult, while if we had positions  
18 based rurally and there needed to be quarantined positions  
19 in the metro hospitals for rural trainees to rotate through  
20 them, while, you know, previously, it's very difficult for  
21 our trainees actually to get access, and until we've  
22 managed to establish the rural and regional training scheme  
23 here, the trainees would spend two years with us and then  
24 they'd actually need to go and apply again for a position.  
25 Sometimes, they would then sort of start at the bottom of  
26 the ladder and work their way up to the specialised units,  
27 which is not fair, because they would be third year  
28 registrars.

29  
30 Q. In terms of the training positions for specialist  
31 training, does that require engagement with the respective  
32 colleges to put into place the opportunity that you  
33 identify in paragraph 21(a)?

34 A. Most definitely. I think we need to appreciate that  
35 the positions belong to NSW Health, but the accreditation  
36 of the position belongs to the college, and I think where  
37 there are challenges is where colleges with very good  
38 intentions stray into industrial and other employment  
39 arrangements as part of accreditation.

40  
41 Q. What do you mean by that?

42 A. They do sometimes, you know, have broader requirements  
43 of hospitals that is not necessarily directly related to  
44 training. A classic example of colleges that recommend  
45 specific amounts of what they call clinical support and  
46 non-clinical time as particular fractions, and, you know,  
47 I had the accreditation by the college of anaesthetists

1 reasonably recently, and the amount of time that they, you  
2 know, suggested was far in excess of what we could deliver  
3 and really far in excess of what the clinicians working and  
4 training registrars felt was required.

5  
6 I think it should be allocated as needed. It should  
7 not be fixed percentages of time, and that's very difficult  
8 for us to do. So I think it is important that there needs  
9 to be clarity for the colleges of exactly what their role  
10 is in this process. They're there to be the custodians of  
11 academic standards, trainee wellbeing is obviously very  
12 important but, you know, if the registrars are NSW Health  
13 employees, we have a responsibility to them as well, so  
14 I would expect that we would manage that ourselves in any  
15 case.

16  
17 Q. I'll ask this in a general way and please tell me if  
18 you can't answer it in that way --

19 A. Yes.

20  
21 Q. -- do you perceive that the colleges are willing to  
22 bring flexibility to their models to facilitate more  
23 training of specialists in rural and regional locations?

24 A. I think some colleges are more flexible than others,  
25 but most definitely. I think a very good example is the  
26 college of psychiatry. They are very, very supportive, and  
27 the college of anaesthetists are supportive and, you know,  
28 when we explained our scenario, they were happy to  
29 compromise, so I definitely believe that the colleges would  
30 be happy to work with the different states to facilitate  
31 training.

32  
33 Q. And I take it from that answer that you see there's  
34 scope for more training in other specialist disciplines in  
35 rural and regional locations?

36 A. Most definitely. I think where we need to be a little  
37 bit more flexible is supervision. It's quite fascinating  
38 that we see virtual care as suitable for patient care but  
39 it's not always seen as suitable for supervision. So  
40 I think we need to re-look at how we deliver care, how we  
41 deliver training. You know, we even use virtual assessment  
42 in Murrumbidgee where I can virtually look at someone  
43 performing BLS. It really is just, you know, we need to  
44 think more broadly.

45  
46 Q. Is there work being done in that area, to your  
47 knowledge - that is, engagement with the colleges about

1 these types of requirements?

2 A. We have been in discussion with the college of  
3 physicians in regard to a palliative care position that  
4 we've had.

5

6 Q. When you say "we", you mean the district?

7 A. The district, yes. And we definitely hope to have  
8 some form of virtual supervision for our new position.  
9 Once again, though, it's the first year that we're going to  
10 have the role, so we can understand that the college would  
11 be a little bit reluctant to, you know, have a new position  
12 and new trainee and then a new way of supporting. But  
13 I think the good thing for us is that we see it always as  
14 an opportunity to positively engage, you know, with  
15 colleges, and remember, we are members of colleges, too, so  
16 we're part of the college as well. So it really is just  
17 that positive collaborative relationship that we should  
18 have.

19

20 Q. Do you think there would be benefit in perhaps some  
21 established protocols between NSW Health as a broader  
22 system and each of the colleges to enable these sorts of  
23 discussions to take place as and when needed?

24 A. Most definitely. Most definitely. I think if there's  
25 a shared understanding it just speeds things up a lot.

26

27 Q. In paragraph 21(b) you identify the rural areas would  
28 benefit from more generalist multiskilled specialists?

29 A. That's correct, yes.

30

31 Q. Can you just expand on that concept, please?

32 A. So I think the first thing to remember is that apart  
33 from the US, Australia has the largest number of  
34 sub-specialties in the world, which is quite fascinating.  
35 We have a very large country, sparse population, and we are  
36 very, very sub-specialised.

37

38 Now, there are benefits to sub-specialisation because  
39 you have experts managing every condition, but if you're  
40 a patient that has more than one condition, you need lots  
41 and lots of specialists to look after you, and if, as  
42 currently is in New South Wales, those services are  
43 delivered in private rooms, where co-payments are designed  
44 between the practice and the patient, it can have quite  
45 a significant financial burden, and especially patients  
46 with multiple chronic illnesses are normally more  
47 vulnerable as well.

1  
2           So it's absolutely essential that for specialists to  
3 work in rural and regional areas, they need to be  
4 multiskilled, which is actually more so than  
5 a sub-specialist, and I think we first need to change the  
6 status of a so-called multiskilled specialist, because, you  
7 know, they actually need more skills to be able to manage  
8 more conditions than a doctor that only manages one  
9 particular condition.

10  
11 Q.   Aside from that change in status of multiskilled  
12 specialists, how can the system address the need on the one  
13 hand, particularly in rural and regional areas, for  
14 multiskilled specialists against the trend of increased  
15 sub-specialisation?

16 A.   I think we need to look at the way services are  
17 remunerated. It is biased towards procedural specialties.

18  
19 Q.   What do you mean by that?

20 A.   Well, it just means that a doctor can earn more money  
21 doing procedures than they can to see patients, and  
22 I think, you know, that is a challenge.

23  
24 Q.   Is that a disincentive, in your view, to the type of  
25 multiskilled specialists that you identified?

26 A.   Most definitely, because there's security in being  
27 a master of a very small field, while if you have to manage  
28 a broader range of conditions, you have to be a little bit  
29 more vulnerable because you may be presented with something  
30 that you're not that familiar with, and clearly,  
31 generalists, because they can do more, there's a potential  
32 that they have more on-call commitments.

33  
34 Q.   In paragraph 25 and 26 you refer to some funding  
35 challenges.

36 A.   Yes.

37  
38 Q.   In paragraph 25 you highlight that the district  
39 doesn't have control over demand for its services --

40 A.   That's correct.

41  
42 Q.   -- where surgery is one?

43 A.   Yes.

44  
45 Q.   And you say that can lead to an unfavourable budget.  
46 How does that arise?

47 A.   Yes, so in my role as the general manager of Wagga



1 Base, I'm responsible for the budget and we are essentially  
2 funded for, you know, a particular bulk of activity or  
3 number of widgets. But if we look at this year, we're  
4 already about 10 per cent above our funded target, which  
5 then means that even if I could deliver the services at  
6 absolute cost, I'd still be, you know, a significant amount  
7 overspent in my budget, and even when it is adjusted, it's  
8 adjusted after the fact. So it is very difficult when  
9 there's, you know, projected activity, but there should be  
10 an opportunity for us to be able to access funding; if we  
11 see that the activity is going up, we should be able to  
12 access funds, you know, before the next year.

13

14 Q. Just go back a step briefly, if I may?

15 A. Yes.

16

17 Q. With your general manager of the hospital hat on, how  
18 does the budget allocation process work?

19 A. Well, so there's obviously the state sets up  
20 a purchasing agreement with a local health district and  
21 then, as part of that, the district's finance team  
22 distributes the budget to different facilities, and Wagga  
23 Base will get a block of funding and then we then allocate  
24 it to different services but --

25

26 Q. Is that block of funding tied to an activity target?

27 A. That's correct, because Wagga Base is an activity  
28 based hospital, so, you know, the state would purchase, you  
29 know, X number of procedures. They have an NWAU value  
30 attached to them and that's pretty much the revenue for our  
31 business. But if the activity then goes up, there's not  
32 necessarily funding, you know, to accommodate for that.

33

34 Q. So that poses two challenges, to you as a general  
35 manager? One, the activity still needs to be done?

36 A. Yes.

37

38 Q. But the budget envelope may not cover it; is that  
39 right?

40 A. That's correct, yes.

41

42 Q. And then, two, does it act as a disincentive to  
43 complete activity in that budget year?

44 A. We're focused on patients. Our role is to look after  
45 them. So, you know, we do the work, and what really try to  
46 do, as we do in rural areas, we try to be as efficient as  
47 possible to limit the financial impact of the additional

1 activity.

2

3 Q. In an earlier answer you said that there is an ability  
4 to obtain budget supplementation --

5 A. That's correct.

6

7 Q. -- but it happens after the event?

8 A. That's correct.

9

10 Q. What challenge does that pose to you as general  
11 manager of the hospital?

12 A. Well, it means that on a month-to-month basis, you  
13 know, I may have an unfavourable budget, which would then  
14 also reflect on the financial position of the health  
15 district.

16

17 Q. That unfavourable budget, would that reflect  
18 unfavourably in your KPIs as a facility?

19 A. Yes, because financial sustainability is an important,  
20 you know, KPI for us.

21

22 Q. In terms of that KPI, however, there's little that you  
23 could do about it, because you're meeting the demand for  
24 services; is that fair?

25 A. That is correct. But I also have a responsibility to  
26 be as efficient as I possibly can, and that's why we're  
27 constantly looking at improving our services and the way we  
28 deliver, and strategies like, for instance, day surgery  
29 joint replacements, reduces the cost quite significantly  
30 for us to provide that particular service, while we still  
31 get the same funding. So that's - as I mentioned  
32 previously, we need to think differently about the way we  
33 deliver care to make it more efficient.

34

35 THE COMMISSIONER: Q. I assume for that, though, you've  
36 got to be careful about picking patients that are right for  
37 a day surgery for a hip replacement, because that won't be  
38 everyone?

39 A. No, that is correct, and that's why we're actually  
40 looking at expanding that model through our "Hospital in  
41 the Home" service, where the patient is not necessarily  
42 suitable as a day case but we could get them home a day  
43 earlier with support services that we've got in place.

44

45 Q. And I assume patients that are thought to be suitable  
46 for day surgery for a hip or a knee replacement - that's  
47 discussed with the patient?

- 1 A. Oh, most definitely.  
2
- 3 Q. How that's going to happen?  
4 A. Yeah. It's done by the specialist when they actually  
5 are consulted initially, and there's actually a process  
6 that they need to go through. It's not a - you turn up and  
7 they say, "By the way, you'll be going home this  
8 afternoon." There's quite an extensive process of  
9 education. They meet the allied health staff before, they  
10 will meet the "Hospital in the Home" staff. So there's  
11 a significant investment for us, but the return is  
12 infinitely more than the time we invest.  
13
- 14 Q. So assuming everything goes well with a particular  
15 replacement procedure, the patient either knows it's going  
16 to be: I'm going to go home that night or it's going to  
17 be --  
18 A. Yes.  
19
- 20 Q. -- 36 hours, 72 hours, is the estimate?  
21 A. Yes.  
22
- 23 Q. And they know that in advance, obviously?  
24 A. Yes, yes, most definitely. There's definitely a plan,  
25 and we call it our criteria-led discharge, where there's  
26 actually a pathway, and there may be times when we have to  
27 vary from the pathway --  
28
- 29 Q. Things can go wrong?  
30 A. That's discussed with the patient, but most  
31 definitely, yes.  
32
- 33 Q. "Wrong" might be the wrong word.  
34 A. Well, unplanned, or it may be that someone's going so  
35 well that they can actually go home sooner, and most  
36 patients actually are keen to get back --  
37
- 38 Q. Then there is a clinical decision made, "This patient  
39 has actually exceeded expectations for recovery" --  
40 A. Yes.  
41
- 42 Q. -- "we think they can go."  
43 A. You know, it's always focused on the quality of care.  
44 We never have finances as the main priority when we deliver  
45 care.  
46
- 47 Q. Well, that would be really dangerous.

1 A. We would never do that. It's --

2

3 THE COMMISSIONER: Sure.

4

5 MR GLOVER: Q. In terms of the way that the budget is  
6 allocated to the Wagga Base Hospital and the challenges  
7 that you've identified in your evidence today, what could  
8 be done differently to support you as a general manager of  
9 a facility like the Wagga Wagga Base Hospital?

10 A. We're extremely well supported by the district.  
11 I think probably one of the areas that I've seen change  
12 over the years is the closer synergy between clinical staff  
13 and the finance and performance team. They are really part  
14 of the team that deliver care.

15

16 If I look at it, I probably speak to my finance  
17 manager as frequently as I speak to the director of nursing  
18 or the director of medical services. They're just part of  
19 the team. Because they have access to all the data,  
20 they're professional experts that can identify trends for  
21 us very early, which then allows us to change the way we  
22 deliver care.

23

24 The classic example for us was the urgent care  
25 service, where we looked and saw that the cost of our  
26 emergency department was increasing, while the complexity  
27 had remained the same, and we said, "Okay, but why is  
28 that?" And we then had a look at, well, is there  
29 a different way to deliver those services? And we were  
30 lucky that we had the ambulatory care services and we could  
31 utilise existing resources. In my statement, I mention  
32 about repurposing resources. The solution is not always  
33 more; it's just different.

34

35 Q. So that's what works well in your district?

36

37

38 Q. But you're still faced with a situation where you  
39 can't control demand and you have occasionally unfavourable  
40 budget results?

41

42

43 Q. What could be done differently to take that pressure  
44 away, at a system level?

45

46 A. I think there should be some way for the system to  
47 adapt. Even though we have projected activity, there  
should be a way for us to adjust funding if activity, you

1 know, exceeds what's planned. You know, as part of the  
2 process, the targets are adjusted and --

3  
4 Q. In-year, do you mean?

5 A. No, I think it's adjusted every two years. It's not  
6 as quick, but, you know, we'd predicted that the activity  
7 would go down to baseline, but it's not, and there needs to  
8 be a way, you know, for us to be able to manage that.

9  
10 Q. In paragraph 26 of your outline you state that funding  
11 new models of care can be challenging within the ABF?

12 A. Yeah.

13  
14 Q. What's challenging about funding new models of care  
15 within an activity based funding structure?

16 A. So when we move services to a different model, it's  
17 not that one day we switch off one service and start the  
18 new one. So there will be a period of time where you have  
19 to run both, and that's the venture capital that we need.

20  
21 The other problem is that it actually takes a long  
22 time for us to effect change. New models of care, if  
23 I look at it, we started the rapid access clinic more than  
24 12 months ago, and we're still expanding. We've only just  
25 added paediatric patients. We're still facing some  
26 challenges with the Healthdirect platform, even - you know,  
27 there was lots of discussion about the ageing population.  
28 So we saw that with data and commissioned a specialist  
29 acute geriatric unit more than 12 months ago, but we're  
30 still working our way through trying to demonstrate the  
31 financial benefits of the service.

32  
33 Q. So is the challenge --

34  
35 THE COMMISSIONER: Q. It may not be clear for a long  
36 time. I mean, evaluation can't be done --

37 A. You know, it's very, very difficult because you need  
38 matching, because the most complex patients go to the acute  
39 geriatric service, which is the best for them. But if you  
40 then go and look at a crude measure, like length of stay,  
41 well, the length of stay is long, but we don't know how  
42 much longer they would have stayed if they were in a  
43 different ward, and I think part of the problem with our  
44 data is that we measure the things that are easy to  
45 measure, that we can count, and it's those other, more  
46 nuanced outcomes for patients that is more difficult to  
47 measure, and that's really what we need.

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THE COMMISSIONER: I cut you off.

MR GLOVER: No, that's fine.

Q. So is the challenge in the ABF framework the need to fund the initial standing up of these programs?

A. Yes, that's correct.

Q. And is the challenge in the ABF framework that you as a facility have been given a budget based on --

A. That's correct.

Q. -- purchasing of activity?

A. Yeah.

Q. How do you perceive that challenge to be overcome?

A. We need venture capital.

Q. When you say "venture capital", are you talking about some block funding at the start to stand up these programs?

A. That's correct, yes, yeah. And we have been - so the urgent care service at Wagga Base has been allocated more than \$2 million to stand it up, so there definitely are some benefits for it.

Q. What about ongoing funding?

A. Well, if I look at our current financial results, it would actually be very easily self-sustainable. It's - from a financial point of view, it's one of our best performing services.

Q. That's an example of a program that has been stood up and seen relatively immediate benefits; correct?

A. That's correct, yes.

Q. There may be others which would take longer to realise?

A. Yeah. So the acute geriatric unit would take longer to be able to do that. The "Hospital in the Home" program, you know, even things like collaborative commissioning, especially with chronic diseases, the true benefits will be years down the track.

Q. So are the challenges in the ABF environment that you're referring to, one, the need to have some initial funding to stand them up?

1 A. Yeah.

2

3 Q. And then certainty of funding going forwards?

4 A. That's correct.

5

6 Q. And so what could be done differently in that  
7 scenario?

8 A. Well, I still believe there should be a proportion of  
9 funding allocated to different models of care to be able to  
10 do it, which is in addition to the ABF funding for the  
11 activity.

12

13 Q. Block funding?

14 A. Yes - well, you know, it can't necessarily be ABF,  
15 because when you stand up the service initially, there  
16 would be certain overhead costs which are inherent,  
17 irrespective of the activity.

18

19 Q. What about the length of the commitment of funding of  
20 that kind?

21 A. Yes, I think the commitment of the funding should be  
22 matched to the time frame that we believe it would take to  
23 demonstrate the outcomes and that would vary between  
24 different initiatives.

25

26 Q. Can I move to a different topic. We've heard some  
27 evidence this week about discharge summaries?

28 A. Yes.

29

30 Q. Is that something that's within your remit? I take it  
31 by that answer it might be?

32 A. Oh, yes, no, it's - so as the district director of  
33 medical services, overall I'm responsible for the medical  
34 services in the district, and I can assure you that  
35 discharge summaries is as much of a priority for us as it  
36 is for other clinical staff.

37

38 I think when we speak to our team, it is handover of  
39 care. It's not a discharge summary; it's actually handing  
40 over care to another health care provider. We do face  
41 challenges at the really busy sites, so especially Wagga  
42 Base. You know, most recently there were about 500  
43 discharge summaries that were overdue past the 48 hours,  
44 and we have a robust system to engage the consultants  
45 because the system is different, that even though the  
46 admitting consultant is responsible for that clinical  
47 handover, the task is delegated to junior members of the

1 team, and writing discharge summaries is a skill that's  
2 acquired over time, and there were some comments from the  
3 general practitioners that some of the discharge summaries  
4 are a little bit comprehensive, but that is junior doctors  
5 that are worried that they'll miss something.  
6

7 So what we actually do is, as part of orientation,  
8 there's training about discharge summaries, and we've  
9 actually had GPs come and speak to the junior doctors and  
10 say, "As a GP, this is what I want in my discharge  
11 summary."  
12

13 The district actually has a working party to improve  
14 timeliness of discharge summaries, the quality of discharge  
15 summaries, and also working on a patient friendly discharge  
16 summary that's more appropriate. But from a governance  
17 point of view, if a consultant has 10 overdue discharge  
18 summaries by more than 10 days, they actually get contacted  
19 by the director of medical services and the expectation is  
20 then that they reach out to their team. If we believe it's  
21 becoming a problem, we then also, at times, have engaged  
22 some contingent workers to help us and make sure that the  
23 discharge summaries are completed as soon as possible.  
24

25 THE COMMISSIONER: Q. Who is on the working party in  
26 each of --

27 A. So it's multidisciplinary. So it's medical, nursing,  
28 allied health as well, and really it's just a process for  
29 us to improve it, because it works well in the non base  
30 hospital sites where the doctors pretty much do a discharge  
31 summary to themselves. It is a little bit more tricky when  
32 you're the junior doctor in the medical team where there  
33 are 30 patients, we discharge 10 today, plus you still have  
34 to do all your other tasks.  
35

36 MR GLOVER: Q. So the two issues, or concerns we've  
37 heard evidence about, are timeliness?

38 A. Yeah.  
39

40 Q. Do you accept that there is a portion of discharge  
41 summaries that are not delivered, I think you said, within  
42 the 48 hours?

43 A. There would be a number of discharge summaries that  
44 are not delivered. Having said that, though, when we  
45 transfer patients to peripheral hospitals, there's actually  
46 a clinical handover between clinicians, so one of the team  
47 at Wagga Base will contact the accepting doctor, and the



1 benefit is that if the doctor is one of our GP VMOs, they  
2 have access to the electronic medical record. Where it is  
3 challenging, though, is that if they don't hold an  
4 appointment with the LHD, then they unfortunately have to  
5 wait until that discharge summary is sent to them or it is  
6 uploaded to My Health Record.

7  
8 Q. Do I take it you accept there is an issue with the  
9 timeliness --

10 A. Yes.

11  
12 Q. -- of discharge summaries within the district?

13 A. Yes.

14  
15 Q. The second issue we have heard is the content of the  
16 discharge summary?

17 A. Yes.

18  
19 Q. You mentioned a concern about some of them being  
20 overly comprehensive?

21 A. That's correct.

22  
23 Q. What about the opposite?

24 A. I must say I've not heard from GPs that it's too  
25 brief. The most of the concern is that, "Due to the nature  
26 of him, oh, you can pretty much include everything", so  
27 every test, every result will be in there, and if you're  
28 a busy GP, that's not what you want to see. So a lot of  
29 focus for us is about training doctors to provide  
30 a succinct and appropriate clinical handover, and really  
31 what the GP wants to know is, you know, why was the patient  
32 in hospital, what did we do, did we change anything in  
33 terms of medication, which is very important, and most  
34 importantly, what would we like them to do? Unfortunately,  
35 it is a skill that's acquired and it's one of the areas  
36 that I actually focus on with my medical students. It's  
37 about - that's a skill that needs to be acquired over time.

38  
39 Q. I take it you would agree with the proposition that  
40 the discharge summary is important?

41 A. Most definitely.

42  
43 Q. In the ongoing care of the patient?

44 A. Yes.

45  
46 Q. And is that one of the reasons why the working party  
47 has been stood up?

1 A. Well, we obviously would like to meet the KPI of  
2 48 hours and we want our GP colleagues, you know, to have  
3 positive things to say about our discharge summaries. So  
4 it is important for us and it's - you know, we engage with  
5 them on a regular basis and we want to have a positive  
6 engagement.

7  
8 Q. Is the district doing any auditing of discharge  
9 summaries, whether as to timeliness or content?

10 A. So most of the audit is actually done in terms of  
11 timeliness. Clearly, if we get feedback about a discharge  
12 summary that is not accurate or, you know, too  
13 comprehensive, we can feed back, so we essentially get  
14 a weekly report of the number of discharge summaries that  
15 are outstanding. And from memory, the medical records  
16 department would occasionally do some audits to actually  
17 look if it meets the minimum requirements, but the minimum  
18 requirements are really the minimum requirements; it's not  
19 necessarily a good quality discharge summary but it's got  
20 the minimum information that needs to be on it.

21  
22 Q. So the measurement of timeliness is measuring just one  
23 of the issues that has been raised with you about discharge  
24 summaries; correct?

25 A. Yeah, that's correct, yes.

26  
27 Q. What work is being done to measure whether, to pick up  
28 your language, there's an improvement in the quality of  
29 discharge summaries and also whether they are patient  
30 friendly?

31 A. Well, so a patient discharge summary would be  
32 different to one that's sent to a clinician, so that's an  
33 area --

34  
35 Q. Just to answer my question, is there work being done  
36 to measure whether there's an improvement of the quality of  
37 discharge summaries as part of the working party that  
38 you've stood up, or is it only measuring timeliness?

39 A. Well, the timeliness is measuring at all times, but  
40 part of the working party is actually to improve the  
41 quality with education and training.

42  
43 Q. I understand that's part of the working party, but  
44 what measurement is being done to determine whether it's  
45 achieving that outcome?

46 A. I would need to check with the other members of the  
47 working party if we've got a formal evaluation of the

1 quality of the discharge summary.

2

3 Q. That would be important, to assess the effectiveness  
4 of the working party's work, would it not?

5 A. Well, I would probably focus on feedback from the GPs,  
6 because, in the end, it's probably more important that the  
7 GPs feed back that they're happy with the quality of the  
8 discharge summary than us assessing, because they're the  
9 consumers of the discharge summaries. So if I was doing an  
10 evaluation, I would probably do a survey with --

11

12 THE COMMISSIONER: Q. Is there GP representation on the  
13 working party?

14 A. I would need to check the exact membership, but we  
15 obviously have GPs that work for us and they can be part of  
16 that.

17

18 MR GLOVER: Q. Finally, can I ask you about VMO  
19 payments --

20 A. Yes.

21

22 Q. -- or payment claims. Is that something that falls  
23 within your remit?

24 A. Yes.

25

26 Q. We've heard some evidence earlier in the week about  
27 concerns from GP VMOs around issues regarding payments  
28 being rejected or delayed. Are you aware of concerns of  
29 that kind being raised within the district?

30 A. Yes. We've had, you know, feedback from some  
31 clinicians where they feel that their claims are delayed,  
32 yes.

33

34 Q. And has there been work done to address those concerns  
35 when they have been raised --

36 A. Yes, so --

37

38 Q. -- to investigate them?

39 A. Most definitely, we do. So I think what's important  
40 is the process of VMO claims management. So VMOs are  
41 contractors. They provide contracted services to us and  
42 they provide invoices to us like other suppliers would do,  
43 and clearly, we have a responsibility to the Australian  
44 taxpayer to be responsible with expenditure.

45

46 So MLHD spends approximately \$60 million a year on VMO  
47 payments, and as part of that process, we have a system

1 whereby we verify claims. The vast majority of claims are  
2 actually paid without any inquiries being conducted, and  
3 it's - at Wagga Base, about 98 per cent of individual  
4 lines, so individual items, are actually paid without any  
5 further information being required.  
6

7 We would then occasionally reach out to a clinician  
8 and say, "There's something that's not clear from the  
9 medical record", or, "There is a discrepancy", and in most  
10 cases, those claims are then paid as well. So the fraction  
11 of claims that are not paid at all would be very, very  
12 small.  
13

14 Q. One of the concerns about which we've heard evidence  
15 in that scenario is the effectiveness of the communication  
16 between the relevant area of the district responsible for  
17 assessing and paying claims and the clinician. Is that an  
18 issue that has come to your attention?

19 A. I think that there's two different services that  
20 manage this. So there's clearly the base hospitals, where  
21 there is very strong process, and that's really led by the  
22 clinician. And we contact them in a way that they would  
23 like to be contacted, either through their practice manager  
24 or to themselves, and it's really not a rejection; there's  
25 an inquiry to say "The following line" - it normally is,  
26 "We need more information from the medical record to  
27 justify payment of the claim."  
28

29 The Rural Doctors' Settlement Package hospitals are  
30 obviously widely distributed and you have lots of different  
31 staff doing small volumes of claims which can make it  
32 tricky, and in a lot of cases, the communication would be  
33 between the facility manager and either the clinician --  
34

35 Q. These are individual instances. Do I take it from  
36 that answer you're not aware of any wider systemic concerns  
37 being raised as to the quality of communication between GP  
38 VMOs and the areas in the district responsible for  
39 assessing and payment of claims as to the adequacy of  
40 communication?

41 A. Well, there's a process where the facility would reach  
42 out to the doctor. I think we need to be careful about  
43 looking at individual circumstances and extrapolating that  
44 to a district-wide. So it could be that particular  
45 individuals have more challenges with claims management,  
46 but the vast majority of doctors find it a reasonable  
47 seamless process.

1  
2 MR GLOVER: Thank you, Professor Bruce. That's all the  
3 questions I have.  
4  
5 MR CHIU: I have no questions, Commissioner.  
6  
7 THE COMMISSIONER: Professor, thank you very much for your  
8 time. We're very grateful for your evidence and you are  
9 excused, thanks.  
10  
11 **<THE WITNESS WITHDREW**  
12  
13 THE COMMISSIONER: Shall we have a short break before --  
14  
15 MR MUSTON: It is probably convenient, otherwise the next  
16 witness will spend seven minutes in the box and then be out  
17 again.  
18  
19 THE COMMISSIONER: How long do you think we should take?  
20 Are you comfortable about when we are going to finish?  
21  
22 MR MUSTON: Yes.  
23  
24 THE COMMISSIONER: It's 11.20. We will come back at  
25 11.40. We will adjourn until then.  
26  
27 **SHORT ADJOURNMENT**  
28  
29 MR MUSTON: I call Jill Ludford.  
30  
31 **<JILL LUDFORD, sworn: [11.40am]**  
32  
33 **<EXAMINATION BY MR MUSTON:**  
34  
35 MR MUSTON: Q. Could you give us your full name for the  
36 record, please?  
37 A. Jill Ludford, chief executive of the Murrumbidgee  
38 Local Health District.  
39  
40 Q. You have been in that role as I understand since  
41 August 2014?  
42 A. Correct, coming up for 10 years.  
43  
44 Q. You've prepared a statement for the benefit of the  
45 Commission dated 12 March 2024?  
46 A. Yes.  
47

1 Q. Do you have a copy of that statement you?

2 A. I do.

3

4 Q. Is the content of that statement, to the best of your  
5 knowledge, true and correct?

6 A. It is.

7

8 MR MUSTON: That is exhibit C33.01 and forms part of the  
9 bulk tender.

10

11 THE COMMISSIONER: Thank you.

12

13 MR MUSTON: Q. Can I start by asking you a little bit  
14 about collaboration. A feature of the evidence we have  
15 heard over the past week has been the strength of  
16 collaboration within your district between the LHD and  
17 other associated entities involved in the delivery of  
18 health care to the people of your region. Can I ask you,  
19 what is it about collaboration that you think is important  
20 in the delivery of health care, from the perspective of the  
21 chief executive officer of an LHD?

22 A. So I think I had the benefit in my career of working  
23 in the operations of a local health district, which is  
24 understanding the function and the bread and butter of  
25 running hospitals. And so when I commenced in the role,  
26 I could see the benefits and the potential if we reached  
27 out and collaborated outside of perhaps our own  
28 organisation, but also the importance of reaching into the  
29 clinicians and it was very much a deliberate strategy in  
30 my, I guess, first 12 months, to first of all cement the  
31 relationships within the organisation, because I think the  
32 clinicians, at the end of the day, make the decisions about  
33 patients, but that also means they make the decisions about  
34 the resources and the usage, so there was some work that  
35 was undertaken around improving the clinician engagement in  
36 the first instance.

37

38 Then my deliberate plan then was around communities,  
39 and they included councils, and I have heard evidence  
40 throughout the week, and I do have a formal strategy of  
41 engaging councils, which is every quarter, I invite them to  
42 actually join me in a Teams meeting.

43

44 Q. We'll come back to that. Can I ask you a little bit  
45 about the steps you took to improve clinician engagement in  
46 those early days in the role? What was it that you did  
47 that you felt needed to be changed or changes did you

1 introduce to improve that clinician engagement?  
2 A. So the structure is there for good clinician  
3 engagement. The model by-laws outline all the steps  
4 that one needs to do, but it was actually about trust.  
5 So you can have meetings, but if people do not feel valued  
6 and if an action is not taken from when they raise  
7 concerns, then the trust isn't there. So it was, I guess,  
8 a deliberate focus with the executive team and the  
9 management team in hospitals that clinicians are not there  
10 just to make a lot of requests; actually, what they're  
11 there to do is to provide feedback on how we can improve  
12 what we're doing.

13  
14 So it was all about listening, helping people feel  
15 valued, and then absolutely have an effort to get back to  
16 people in a timely way. If it meant that we couldn't do  
17 what they were asking, then we had to tell them and we had  
18 to tell them why but we had to do so in a way that was open  
19 and transparent.

20  
21 So it was about - really it was about building  
22 relations that within the structures that were in in the  
23 model by-laws. In the first instance that meant that  
24 I actually lent in and got to know people quite well,  
25 you know, developed the relationships with some of the  
26 clinical groups myself, and when they had ideas, they  
27 knew that they could take those forward. You know, 10  
28 years on now, it all happens with the people that you've  
29 met, giving evidence, where they're now empowered to take  
30 those ideas forward. But clinician engagement is very  
31 important.

32  
33 Q. That's the clinician engagement. What about engaging  
34 with, say, other contributors to the delivery of health  
35 service within the district - for example, the PHN?

36 A. Yes.

37  
38 Q. What was the state of that engagement like when you  
39 first arrived in the job? I know you've been here for  
40 a while.

41 A. I can actually remember, when I first started and it  
42 was said to me, "Well, there's no point, actually, asking  
43 the primary health network for help because they don't want  
44 to know about us", and that was really the state of where  
45 we were.

46  
47 Q. Why do you think that was?

1 A. Look, I think some of it can be the different agendas  
2 and some of it can be personalities. But --

3  
4 Q. What did you do to try and turn that around?

5 A. So I guess I'm not really interested in the  
6 personalities; what I'm interested in is the system  
7 approach. So again, I can remember back, I asked if  
8 I could meet with their general practitioners, because  
9 general practitioners were always viewed as contractors in  
10 the district when I started. However, given that they are  
11 a critical part - I've got 31 hospitals and 29 of them are  
12 made up of general practitioners - if we didn't have  
13 a relationship with them or the body that was overseeing  
14 them, then there was something that wasn't quite right.

15  
16 So I had this very first meeting with the general  
17 practitioners, and lots of them came, and I presented them  
18 data about their towns, and I can remember them saying,  
19 "This is the first time we have ever seen this. We don't  
20 actually have a forum to share what happens to our patients  
21 when they go into the public health system."

22  
23 So it started there and then the then chief  
24 executive - and there have been many - agreed that we would  
25 have a joint executive meeting every month.

26  
27 Q. That's the then chief executive of the PHN?

28 A. The primary health network, sorry, the Murrumbidgee  
29 Primary Health Network.

30  
31 Q. Sorry, I interrupted you.

32 A. Yeah, so then that was, I guess, the system approach,  
33 which is if we actually have a forum for coming together  
34 and working out where we actually have some shared  
35 priorities - and it was early days, I think, in the  
36 integrated care thinking, but I could plainly see in our  
37 data that a lot of what we were experiencing in, I guess,  
38 potentially preventable hospitalisations had a direct  
39 synergy with the GPs and the work that they were doing, and  
40 they were very interested in the data, and so we had some  
41 very early collaboration around chronic disease management  
42 and how we could come together. It was very early days in  
43 integrated care. Yes.

44  
45 Q. In a practical sense, how did you go about  
46 facilitating that collaborative approach? Who was involved  
47 in it, I guess, as a first question? Who did you involve



1 in the process of engaging with the PHN in a collaborative  
2 way?

3 A. So like most things, if you want to address a problem  
4 that's wicked, you probably need to put some resources to  
5 it, and so I remember writing a submission to the Ministry  
6 of Health and getting a very modest amount of money to do  
7 this work. So I pulled together a small team, they were  
8 mainly nurses, and there was only three of them, and we  
9 really focused on understanding the data and going out to  
10 each of the general practices, along with the primary  
11 health network person, and sitting down and engaging with  
12 the GPs around what might be possible. It was really  
13 a listening exercise. And then we landed on a couple of  
14 priorities and we started working together.

15

16 Q. In terms of the way you worked together, what was it  
17 about your engagement that you think was - or the way in  
18 which you engaged with the PHN that you think was  
19 effective?

20 A. Having a structure and making sure that we were very  
21 deliberate on making our actions focused on data and  
22 outcomes for patients, and then having, I guess, a system  
23 to report that as well, so that we were holding ourselves  
24 accountable.

25

26 Q. In addition to the work that has been done  
27 collaboratively to date with the PHN, do you see other  
28 future opportunities for collaboration that you think at  
29 the moment are not being capitalised on as well as they  
30 could?

31 A. Absolutely.

32

33 Q. What are they? Feel free to give us a long list.

34 A. Right. Okay. Look, I think if I may just say,  
35 though, that it's very important that you have the  
36 structures in place before you embark on something large.

37

38 Q. So pausing there, when you use the term "structures",  
39 what do you have in mind?

40 A. What I'm really talking about is a level of  
41 governance, so number one, that joint executive meeting,  
42 but what we've now put on top of that is actually our  
43 boards agreeing that this is work we're doing together, and  
44 actually having that subcommittee, that board subcommittee,  
45 that has started just this year, 2024, and that's sealed  
46 with a collaborative agreement, which is based on the  
47 NSW Health and the Australian Government's joint statement.

1 So it all trickles down, it all has to be connected,  
2 because without the governance, it's much more difficult.  
3 If I'm not here tomorrow, it can all fall over, but if you  
4 have put the governance and the system in place, it will  
5 happen no matter who is sitting in the chair.  
6

7 Q. So you've got the structure in place. Where do you go  
8 from there in terms of future opportunities that you see  
9 for collaboration between the PHN and the LHD?

10 A. Well, I know you've heard evidence throughout the week  
11 around the patient-centred co-commissioning group, and  
12 I won't go into the details, but what I will say is that we  
13 started that work before COVID around the planning for  
14 collaborative commissioning, for those two chronic  
15 diseases - chronic heart failure and COPD - and it took us  
16 the best part of two years to actually land on, together  
17 with consumers, mapping that whole pathway.  
18

19 Now, COVID did get in the way of that, but that's  
20 probably the only time in my career where we've had the  
21 luxury of doing proper planning. So often our cycles are  
22 tight, our funding is limited to particular years and we  
23 land on the solution before we understand the problem.  
24

25 Q. So just going back to that comment you made a moment  
26 ago that it's the only time in your career that you've had  
27 an opportunity to do proper planning, let's start with this  
28 concept of proper planning.

29 A. Mmm.  
30

31 Q. What do you regard as being proper planning for the  
32 delivery of either a collaborative project or an attempt to  
33 achieve a particular health outcome? What is it that you  
34 think proper planning involves?

35 A. Yes, it's important that we clarify that point. We  
36 were able to access a different kind of data, which is some  
37 linked and joined-up data from the health system and also  
38 from the primary health sector, so that we could truly  
39 understand, and it was again, preliminary days, but we  
40 could understand much more of that whole patient journey,  
41 not just their experience in our hospital.  
42

43 Q. Did that linkage of the data come through useful  
44 collaboration between the LHD and the PHN or was it data  
45 that became available in some other way as a collective  
46 bundle --

47 A. Yeah.

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Q. -- as a result of the pandemic?

A. That data became available actually through the Ministry of Health, through the collaborative commissioning team, and it was actually called "dynamic simulation data modelling", very, very sophisticated modelling, where it pulled data through something called Lumos, and I don't think Lumos has been mentioned to date but it is actually the de-identified hospital data and the de-identified GP data, pulled together from participating practices into one system called Lumos.

Q. Now, in relation to that, so I understand it, it's de-identified but it is linked, is it, by reference to a single patient identifier?

A. Correct. That's right.

Q. So the data, although de-identified, it gives you greater visibility than you once had of that patient's journey out of primary care into acute care, back out of acute care and into primary care?

A. That's right, yes. And that was a revelation, as you can well imagine. The first step was actually the primary health network collaborating with us and signing GP practices up, and I think we've heard through the week there's about 89 GP practices roughly, and they did an amazing effort and got 35 practices signed up when we were doing that planning process. So that gave us enough data, really - it was approximately half - to be able to make some assumptions and --

Q. So the signing up of the practices, 35 GP practices agreed to have - were signed up and agreed to have their patient data de-identified and brought through this Lumos system so that it could be viewed collectively with the LHD's data; is that right?

A. Yes, that's correct.

Q. Sorry, I interrupted you again.

A. So - no, that is correct. And so then, that data fed into this other dynamic simulation tool. But the beauty of that was, we had the pathway mapped out and we were then able to test if we did X and what that would mean in terms of cost and what that would mean for the patient. So it enabled us to have a little bit of a test ground for different interventions to work out whether they were affordable, whether their outcomes would make a difference,

1 and so that's why that process took so long, because it is  
2 so important, if we are going to invest, that we are going  
3 to get a return on our investment.  
4

5 Q. So when you refer to a return on the investment, are  
6 you referring to a health outcomes return or a return in  
7 terms of a financial benefit and efficiencies within the  
8 LHD's service model?

9 A. It has to be both.  
10

11 Q. How do you measure the former?

12 A. So the former is measured by process metrics, so  
13 things like length of stay in hospital, number of hospital  
14 admissions, things like that; number of presentations to  
15 the emergency department, complications. The health  
16 outcomes, of course, will take much longer to measure, and  
17 that's the evaluation that we're going through now.  
18

19 Q. Do you feel at the moment with the data, the level of  
20 data that's available through, say, Lumos, that you do have  
21 a good sense or a good capacity to measure tangible health  
22 outcomes from the patient's perspective?

23 A. It's very hard to take it down to that granular  
24 individual patient perspective, I would say. It's probably  
25 easier to have a look at a group of patients from  
26 a particular area, because it's very complex data, you can  
27 appreciate. There were pockets of areas where there was  
28 greater disadvantage.  
29

30 Q. Picking up on something one of your colleagues said  
31 this morning, there are things - we measure the things  
32 which are easy to measure, like length of stay, number of  
33 re-admissions?

34 A. Those things.  
35

36 Q. Post-discharge infections, hospital-acquired  
37 infections and the like, which we can measure and are no  
38 doubt important, but would it be right to say that at the  
39 moment, we're not doing a great job of capturing  
40 information about the ultimate impact that some of these  
41 treatments that might be delivered through an acute  
42 setting, for example, are having in a longer term on  
43 a patient's overall life and wellbeing; for example, can  
44 I do the shopping independently, which I might not have  
45 been able to do if I hadn't had that knee operation, just  
46 as an example?

47 A. So some work has begun with the patient reported

1 measures on measuring both patient outcomes using  
2 international validated tools and the tools are different  
3 for different disease cohorts, and also the patient  
4 experience measures, which are also important, and all of  
5 that data is currently - and we've got 73 of our services  
6 where we're actually collecting that data. It has  
7 a twofold impact. One, if the patient fills it out from  
8 their home device before they see the clinician, the  
9 clinician can see if they're not sleeping or they can see  
10 some of the things that they might need to titrate in the  
11 actual visit. But importantly, that data is now going into  
12 the HOPE system, and HOPE stands for patient outcomes,  
13 patient experience system, which is a collaboration with  
14 the Agency for Clinical Innovation, and that data is being  
15 collected at a statewide level in the HOPE system.  
16

17 Q. For what duration, do you know? In terms of that HOPE  
18 information collected from patients as to their perception  
19 of the outcomes, is it immediately post admission and then  
20 for some period thereafter? Do you know?

21 A. Yes, we actually work that out for particular  
22 services. So for example, it might be done preoperatively,  
23 it might be done postoperatively and then three months  
24 later. It just depends on what the validated tool says you  
25 should do it. So it does differ. But there has to be  
26 a consistent approach across the state.  
27

28 Q. A lot of information about longer-term patient  
29 outcomes from interventions within the acute setting might  
30 ultimately rest within the records of your primary care  
31 provider?

32 A. Yes.  
33

34 Q. Is there a way in which attempts are being made to  
35 mine that information or that data from the primary care  
36 setting to make an assessment of patient outcomes delivered  
37 through a particular intervention?

38 A. Yes. So we have started collecting patient reported  
39 measures through some of our general practices as part of  
40 collaborative commissioning. For that very reason, we need  
41 to actually measure the longer-term impacts of the patients  
42 when they finish with our service, yes. So it's early  
43 days, but we are now collecting that data, yeah.  
44

45 Q. Do you think that a regional LHD like yours, by reason  
46 of the closer relationship it might have with its slightly  
47 smaller pool of GPs, has a greater capacity, potentially,

1 than a metro LHD to collect that data through the primary  
2 health setting?

3 A. Oh, I do think that is true, and the reason is  
4 because, well, 100 of those doctors who work in general  
5 practice work with us as well, so we have a much closer  
6 relationship with many of them.

7  
8 Q. So would you be bold enough to suggest that if there  
9 was money to be spent on piloting a collection and  
10 assessment of data through both the acute and primary care  
11 setting with a view to determining patient outcomes through  
12 a particular intervention, that regional LHDs like yours  
13 might be the better place to spend that money than, say,  
14 a large metro LHD which might have within its catchment  
15 hundreds if not thousands of GP practices?

16 A. I would not like to speak on behalf of my metropolitan  
17 colleagues. I was the joint chair of a working party under  
18 the joint statement, we're looking at regional planning,  
19 and I certainly --

20  
21 THE COMMISSIONER: Q. What about if the question was:  
22 would a regional LHD like yours be a good place to do this?

23 A. Yes, that's a simple answer.

24  
25 MR MUSTON: Q. I think we've dealt with some of the  
26 opportunities. Do you feel there are any other  
27 opportunities for collaboration with a PHN that are looming  
28 on the horizon that haven't yet been mentioned and, if  
29 so --

30 A. I do.

31  
32 Q. -- what are they?

33 A. It is in relation to delivery of primary care, if  
34 I may --

35  
36 Q. Yes.

37 A. -- share my thinking. And if I could just start by  
38 saying that we've heard a lot about the fragility of the  
39 primary care sector over the last week, and we've seen it.  
40 But I'm not sure that we've also touched on the fragility  
41 of some of our small hospitals as well, and the main reason  
42 why they are equally as fragile is because of the workforce  
43 issues, and whilst we have seen and heard about the fact  
44 that there are declining numbers of general practitioners,  
45 particularly those choosing to work in rural areas, you  
46 could extrapolate the same for nurses, and my thinking is  
47 that it is going to get harder and harder for us to attract

1 nurses who want to work in a small rural hospital, because  
2 having the skills to work in an emergency department, and  
3 all the other things that we've heard about, is very  
4 challenging, and if we're not training nurses to be those  
5 generalists, then we've got a fragile system on both sides.  
6

7 So I think the collaboration with the primary health  
8 network comes into the picture here because if we take our  
9 learnings from collaborative commissioning around our two  
10 chronic diseases, could we apply that to how we might look  
11 at small communities, and instead of having two fragile  
12 systems - because if we put a patch on one, it's going to  
13 impact the other.  
14

15 So already, if we take primary care presentations,  
16 today in my district I can say that we have 18 per cent  
17 more triage 4s and 5s in those small hospitals than we had  
18 two years ago. Now, that's an alarming rate of primary  
19 care coming in to our EDs, and Professor Bruce said EDs are  
20 not the best place to provide primary care, and  
21 I absolutely agree. It's episodic. It's treating the  
22 symptoms that they're presenting with. It is not doing  
23 anything around their chronic disease management or  
24 whatever they have presented with.  
25

26 Q. Is that, in your view, because the existing primary  
27 health infrastructure within some of those small  
28 communities is not sufficient to meet the needs of the  
29 community, the primary health needs of the community?

30 A. It's demand. There's too much demand, and after  
31 hours, we're it, after 5, and weekends, but also, if  
32 people - it is true that people cannot always get in to  
33 a GP when they need to in some of our smaller communities,  
34 and they may have to wait. So if they feel they can't  
35 wait, they'll go to the hospital as the other alternative.  
36

37 Q. Picking up on a comment you made earlier about the  
38 fragility of the hospital system within those communities,  
39 part of that is challenges in attracting nursing workforce?

40 A. Correct.  
41

42 Q. Part of it is also the historical fact that the  
43 medical workforce within those hospitals has traditionally  
44 been populated by GP VMOs from within the community; is  
45 that right?

46 A. That is right. The same GP that the patient can't get  
47 into, yes.

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Q. So if the GP workforce is insufficient to meet the primary care needs of the community, similar problems translate into the acute care setting, because those same GPs are being stretched even thinner?

A. That's right.

Q. Have you observed that there are changing attitudes within the medical workforce to the way in which - or their willingness to interact as a GP VMO working within a small hospital setting? Perhaps put a better way, once upon a time it was perhaps expected that the local GP would also spend time working in the hospital?

A. Mmm.

Q. Is that expectation something that you can rely upon now or is it less frequent?

A. It has changed, and there are two reasons why. One is because some of the GPs do not have the skills, qualifications or experience to feel comfortable working in a hospital, so will choose not to do so; and the second reason is, because of their own balance within their primary care practice and the demand that I just referred to, if they come in to the hospital - and we heard it on a site visit - then they've got a room full of patients that they then have to reschedule and try and see, so it puts them behind. So it's that balance of skills, balance of demand of their practice, and so that has changed.

They also get a lot of pressure from their communities to work in the hospitals as well and I think that's quite difficult and uncomfortable for them. But we are seeing more and more practices that are reducing the amount of time that they have to spend working in the hospital.

Q. Is part of that challenge also from the GPs' perspective, the fact that they have, in addition to meeting the needs of the patients, an economic imperative to see patients so that they can pay their receptionist, their practice nurse, their rent, if they're paying rent?

A. Yes, I believe that to be true.

Q. We've heard a lot about the single employer model within the district as a project which has been in many respects very successful in attracting people to train as rural generalists through a salaried model. My understanding of it, and correct me if I'm wrong, is at the



1 end of the training period, that the participants in the  
2 program work through, they are released out there into the  
3 GP market and they don't remain as a salaried primary  
4 health provider within the LHD system.

5 A. Mmm.

6  
7 Q. Do you think there is scope within communities where  
8 the market based - existing market based system is not  
9 adequately providing for the primary health care needs of  
10 the community, for a salary based system to be introduced  
11 in order to better meet that need?

12 A. Just seeking clarification: are you talking about the  
13 need in the hospital or the need in primary care?

14  
15 Q. Both. So to be blunt about it, to take a practitioner  
16 on a salaried model to operate within a small community as  
17 a provider of primary care through rooms, perhaps rooms  
18 attached physically to the hospital but not the emergency  
19 department, but also to continue to provide the role that  
20 was historically provided in that town perhaps by GP VMOs  
21 working through the hospital system - very much --

22 A. No, I understand the question.

23  
24 Q. -- town specific, though

25 A. Yes. The answer is, I think there's as much a role  
26 for those rural generalists, is what they come out as, to  
27 be employed on a salary to support delivery of procedures  
28 and even managing an emergency department across a number  
29 of sites. So the next step in the model, in my head, has  
30 always been around employing those rural generalists as  
31 staff specialists but more as proceduralists, to perhaps do  
32 anaesthetics across three or four, you know, medium sized  
33 hospitals, where they can get the volume and keep their  
34 experience going, and also support emergency departments,  
35 because that is one of our biggest challenges, is in the  
36 sites where we really have the volumes, like Tumut, where  
37 you were, staffing those emergency departments is becoming  
38 more and more challenging, as GPs need to focus on primary  
39 care.

40  
41 Now, your question, though, was could those salaried  
42 doctors provide primary care, and my answer would be that,  
43 I want to go back to your question about the primary health  
44 network, because I think if we actually took an approach  
45 where we had a regional plan and then we pulled together  
46 council, PHN, local health district, any industry partners,  
47 Snowy Hydro or the gold mine in West Wyalong, and we came

1 together and said, "What are the needs of this community,  
2 what are the resources and how can we best provide it or  
3 commission it?" And I think that the decision about who  
4 should provide primary care needs to come from that group,  
5 and it could be a Dr Alam Yoosuff group, or it could be  
6 a different group, or it could be that staff specialist who  
7 has just finished their rural generalist training, but I do  
8 think it should be that patient-centred co-commissioning  
9 group that manage that, not the district.

10  
11 Q. Would it be right that community by community, the  
12 situation and the solution will be very different?

13 A. Yes.

14  
15 Q. A community that has a number of GPs, perhaps  
16 sufficient to meet the primary care demands if they're not  
17 spending half of their time in a very busy emergency room  
18 in a small hospital, perhaps employing staff specialists to  
19 deliver that emergency care or pick up more of that burden,  
20 might be a solution for that community?

21 A. Mmm-hmm.

22  
23 Q. Perhaps we'll come back to it, but incentivising  
24 a shift into those positions through increase in procedures  
25 through those small facilities, through that particular  
26 small facility?

27 A. Mmm-hmm.

28  
29 Q. In another community that sees very few patients in  
30 emergency and has an insufficient market based deliverer of  
31 primary health care, a staff specialist whose day-to-day  
32 job is principally the delivery of primary health care in  
33 the conventional way, providing support to emergency and  
34 admitted patients and potentially aged care patients in an  
35 MPS type environment, might be a very different solution in  
36 that town --

37 A. Mmm-hmm.

38  
39 Q. -- would it be right to say, or would you agree, that  
40 the appropriate way to approach the problem is to identify  
41 the needs and the solution as the first priority, and then  
42 work out who's going to pay for it and how it's going to be  
43 paid for in this collaborative way that you've discussed,  
44 as step two?

45 A. Yes. That's right. But it's not - it should not be  
46 an automatic assumption that the local health district  
47 necessarily employs that staff specialist. They could be

1 commissioned in another way, where they work half the time  
2 for the hospital and then half the time in the primary care  
3 practice doing their bulk billing, and that's part of the  
4 model that's developed in that PCCG, yeah.

5  
6 Q. We've heard a little bit about the Four Ts project,  
7 where, as we understand it, the staff specialist is  
8 employed by the LHD full time to deliver the care, but an  
9 arrangement has been made with the Commonwealth which  
10 permits that staff specialist to access them --

11 A. Yes.

12  
13 Q. Yes?

14 A. That is one model.

15  
16 Q. That's one model?

17 A. Mmm.

18  
19 Q. And again, community by community, the most  
20 appropriate might be different?

21 A. Yeah.

22  
23 Q. But the starting point should always be identifying  
24 the need and the solution?

25 A. Yes.

26  
27 Q. Rather than asking what the existing funding models,  
28 disparate as they are, might be able to deliver to  
29 a particular community?

30 A. Yes. It's my view that that needs that joint planning  
31 and it needs a framework - and we're actually working on  
32 one here through our precinct - should happen first; then  
33 the governance model; and then working out what it looks  
34 like within the existing resources, yes.

35  
36 Q. And it's likely that an LHD will have a better  
37 understanding of the, in your case, 506-odd communities  
38 that you have --

39 A. Yes, 508.

40  
41 Q. I think I said 503 yesterday, so I'm getting closer.  
42 508 communities that you serve, than, say, the ministry  
43 might have at a central level - that is to say, you at the  
44 LHD will have a better understanding of those communities  
45 and their unique features --

46 A. Yes.

47

1 Q. -- than a central authority? In terms of a process  
2 for identifying the needs and the best solution for the  
3 delivery of integrated primary and acute care in those  
4 communities, how do you think - from an LHD perspective -  
5 what structures do you think might the system introduce to  
6 mainly that to happen?

7 A. Because the other part of primary care that we haven't  
8 mentioned is the community nurses, the allied health  
9 clinicians that do the restorative care after the hip and  
10 knee replacement, healthy ageing, the preventative care,  
11 the - you know, the bit that we can do around, you know,  
12 home monitoring of patients with a chronic disease at home,  
13 so those --

14  
15 Q. All of which are tools that you have in the toolbox  
16 when you are trying to build the perfect bespoke solution  
17 for a small community. I guess the question is, is there  
18 something that the system could do to facilitate a process  
19 whereby needs are identified, solution is built out of what  
20 you've got in your toolbox --

21 A. Yeah.

22  
23 Q. -- and then there is some hopefully successful  
24 mechanism by which the various parties that provide funding  
25 into health collaborate to deliver that solution?

26 A. Yeah, because the mechanism needs to be that in those  
27 communities, there is commissioned services from the  
28 primary health network, and then we have our own - the  
29 district has our own community nurses and allied health  
30 staff who are working in fragmented ways. So the mechanism  
31 around integrated care, which could be a framework, needs  
32 to mean that they all come together. Essentially what I'm  
33 saying is we need to break down the two systems and for  
34 these small communities it needs to be one mind set, one  
35 system.

36  
37 Q. In a practical sense, how do you think we might go  
38 about doing that, and to the extent you have been able to  
39 do it in your LHD, if you have, how have you done it?

40 A. And, look, it's not for the faint-hearted. We  
41 actually have got in our collaborative commissioning  
42 project some staff who work for both the local health  
43 district and the primary health network. They do have  
44 a single employer, so we employ some and the primary health  
45 network employs some, but all the decisions - they come  
46 together and work as a team and all the decisions that are  
47 made are made in that group, together - can't happen one

1 without the other.

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So I think there is a mechanism, if you like - what would we call it, a framework, a policy - where there is, I guess, a commitment and there's awards and all sorts of things you've got to look at, but there is a commitment to bring those tools together, those resources, those people together, so that there's one planning document they're working on, there's one implementation plan.

They've actually done this in Canada and they've got a - what do they call it - rural roadmap, and each community's rural roadmap looks slightly different and it's all about primary care, and it's overseen by a department of - I think it's called family medicine, something like that, don't quote me. But I think we would need that sort of framework, such as they set up in Canada, where there's a policy piece that sits there, there's the governing body that oversees all of these different bespoke models, and there is, I guess, more of a collaborative roadmap with a group of people who are overseeing it, because it would need to be measured, it would need to be monitored, there will be problems that need to be solved.

So if essentially we created our own roadmap, our New South Wales rural roadmap, and we actually had a group of people who were responsible for overseeing it writing the framework, the rules, the guidelines, that can be tailored to be a more bespoke model for local communities.

Q. And that roadmap would need to be something that was not only a NSW Health roadmap but presumably a roadmap which was embraced by all of the important collaborators, including the PHN?

A. Yes, that's right. And I think we underestimate the input of some of the other people, like industry partners, because if they've got a large workforce, there's lots of infrastructure builds - Snowy Hydro and Inland Rail and other things - sometimes they've got a sort of an interest, an investment, too, in the region, and I think sometimes we just think too narrowly about how we're thinking about health care, and we need to broaden our thinking.

Q. Part of that, do I take it, is a thought that if there is a large project, be it a mine or a Snowy Hydro project, that's going to bring an influx of people into a small rural area?

- 1 A. We need to know about it.  
2
- 3 Q. First of all, you need to know about it from  
4 a planning point of view; right?  
5 A. Yes.  
6
- 7 Q. Secondly, do I take it that you suggest the entity,  
8 potentially private commercial entity, that has brought  
9 that workforce in to the small area, might have a role to  
10 play in actually delivering the health care to that  
11 increased population for the duration of the project rather  
12 than the local - the existing market or --  
13 A. Mmm-hmm.  
14
- 15 Q. -- publicly funded?  
16 A. It could look like that, or they could invest.  
17 There's a number of options.  
18
- 19 Q. Again, that's just another tool that's potentially in  
20 the toolbox in order to deal with a bespoke solution --  
21 A. Yeah.  
22
- 23 Q. -- provide a bespoke solution for a small town?  
24 A. Yes.  
25
- 26 Q. One of the other critically important collaborators in  
27 all of this within your LHD are the Aboriginal community  
28 controlled health organisations?  
29 A. Yes.  
30
- 31 Q. RIVMED, GAMS, and I think there's a new one being  
32 stood up in Hay that we've been talking about?  
33 A. Hay, and there's Cummeragunja, which is down on the  
34 border around Deniliquin.  
35
- 36 Q. Can I ask what's the process that you have for  
37 collaborating with those organisations?  
38 A. So with the primary health network, we have set up the  
39 Aboriginal consortium, of which they are members, and also  
40 there are other members of the consortium, such as the  
41 primary health network, but also some of their commissioned  
42 service providers, and also our service providers from  
43 within the local health district, and so that consortium  
44 comes together, meets regularly, and has a plan on what we  
45 think our agreed priorities are. Those priorities  
46 obviously are around improving health literacy, access to  
47 services and greater collaboration with us working

1 together.

2

3 But if I could use an example of how we work  
4 together --

5

6 Q. Please do.

7 A. In Griffith, we had, for our cataract surgery, our  
8 single ophthalmologist leave, and it was during COVID, and  
9 obviously eye surgery is very, very important for  
10 a community, and particularly high levels of socioeconomic  
11 disadvantage in that region. And there were some providers  
12 who usually provided services to other countries overseas,  
13 who were suddenly - the borders were shut and they were  
14 unable to do their overseas travel, and so we collaborated  
15 with them to come and work with us in Griffith to, first of  
16 all, provide the cataract surgery which was really, really  
17 important.

18

19 But the model that has since developed is the first  
20 public ophthalmology service in my district, and we did  
21 that in collaboration with the Griffith Aboriginal Medical  
22 Service because it involved training our staff, the GAMS  
23 staff, in doing eye examinations and assessments, and then  
24 we have created the public clinic and then we provide the  
25 surgery, but we have done that in collaboration with GAMS,  
26 and there are many examples and far more opportunities to  
27 work collaboratively with the community controlled  
28 Aboriginal sector.

29

30 Q. What do you think some of the big opportunities are in  
31 terms of improving the collaboration and the outcomes  
32 generated through that collaboration with the community  
33 controlled health organisations?

34 A. It is probably a flip around from the example that  
35 I gave because it is recognising the Aboriginal groups as  
36 the experts and the people with the knowledge about what  
37 their needs are. So in the work that we've been doing with  
38 another group, which is called - our local decision-making  
39 group, so RMRA. I'm just trying to think what it stands  
40 for - Riverina Murray Regional Alliance.

41

42 So with that group which has been established with  
43 Aboriginal affairs, they have determined the priorities for  
44 government. So in the case that I gave you before, it was  
45 we determined the priority, but I think the opportunities  
46 now lie in where they identify the priorities, so there's  
47 three pieces of work they've identified, which we've

1 committed to, whole of government, not just me, education,  
2 communities and justice. One is about health and  
3 wellbeing; the other one is about strengthening families;  
4 and the other is about law and justice.

5  
6 Now, an example of that is that together with treasury  
7 and with Aboriginal affairs, we've actually developed  
8 a business case for a health and wellbeing service,  
9 particularly for people who have got drug addiction. So it  
10 is about actually listening, understanding where the  
11 priorities are from them, and then working together, and  
12 not just as one government entity but as a number of  
13 government entities. So in that case, it was treasury,  
14 Aboriginal affairs and ourselves and one of the community  
15 controlled organisations who worked up that piece.

16  
17 Q. From a process point of view, how is it that you go  
18 about obtaining from the community controlled organisation  
19 that guidance and direction in terms of where that - where,  
20 in their view, that money should be spent and projects  
21 should be delivered? What's the process of engagement that  
22 you have with them?

23 A. So the process of engagement is as much as we can  
24 having a formal agreement with them, if you like, an MOU or  
25 a heads of agreement. But I have to say that that's  
26 important, yes, because you can itemise some of those  
27 priorities, but what is equally important is developing  
28 a level of collaboration and trust. So we've focused on  
29 the collaboration and trust and we have some agreements  
30 with some of our ACCHOs and we're working on getting that  
31 formal agreement with others, but I can say that we would  
32 have made a lot of progress in the collaboration and trust  
33 space, and that takes time.

34  
35 Q. And it's very personality driven on both sides, would  
36 you say, or is there a way that you can implement  
37 structures that mean that it's not so dependent on --

38 A. Yeah.

39  
40 Q. -- two compatible personalities coming together?

41 A. No, definitely there needs to be a system approach to  
42 it. So there is always, we're seeking to have a working  
43 agreement with you, a heads of agreement, and we share our  
44 data. So we have created our own Aboriginal dashboard for  
45 our performance data and it measures some of the process  
46 measures, but it also measures things like our workforce  
47 numbers, 3.6 per cent of our workforce are First Nations,



1 and once a year we actually share that with them and we are  
2 transparent about the things that we're doing well in and  
3 the things that we actually can improve on. We're really  
4 seeking, I guess, to have that exchange of data and  
5 exchange of where we're up to with each other, so that we  
6 can, I guess, then work out the areas that we need to work  
7 on together.

8  
9 There's lots going on, you know, the Wagga Base  
10 Hospital clinicians run clinics over in RIVMED and there's  
11 lots of collaboration that goes on, but above that, at the  
12 consortium level, we do need to have our priorities in a  
13 framework that we agreed on.

14  
15 Q. You started telling us a little bit earlier about your  
16 engagement with local government --

17 A. Yeah.

18  
19 Q. -- as another collaborator. How does that work?

20 A. So once a quarter I make myself available to have  
21 a couple of hours with the mayors and the general managers.  
22 We do it on Teams. I would say to you that it started  
23 during COVID where I actually met with them every month and  
24 I probably spoke to many of the mayors and GMs regularly,  
25 as we had to stand up testing stations and vaccination  
26 clinics.

27  
28 They were absolutely fantastic collaborators, and it  
29 really cemented, I guess, a really great working  
30 relationship and from that we formalised it and we meet  
31 every quarter. There are lots of things that we have in  
32 common around population health. We've got mosquitoes down  
33 here, they're not very nice mosquitoes, and they transmit  
34 diseases, and they have obviously staff who are responsible  
35 for some of that, elements of that. Environmental health,  
36 we do as well.

37  
38 So we talk about, I guess, the intersects of our  
39 council and the local health district, and there's always  
40 a really great rollup to those sessions, with the mayors  
41 and the GMs, and I've just continued that on pretty much  
42 since 2020, yeah.

43  
44 Q. Do you find that through that process you get feedback  
45 about what at least local communities in some parts of the  
46 LHD perceive to be the need --

47 A. Definitely.

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Q. -- and particularly the unmet need?

A. Definitely.

Q. How does that feedback find its way into decision-making about service planning by the LHD?

A. Yeah, so the feedback is collected and we would go back to individual communities separately, rather than through that forum.

And before I touch on how that goes into service planning, I also, when I do my site visits, invite the councils to come and meet with me, so I'm there face to face. Once again, there's always a great take-up on that offer, so we'll sit down, and quite often we'll work out details, and sometimes there are things like, you know, accommodation that - they're doing a housing project or - so there's lots of things that we talk about, and I've got a particular person in my chief executive team who looks after the relationship with councils and we feed back to the planning team information that relates to service planning.

Q. To the extent that we've heard local governments often play a significant role in terms of trying to recruit and retain medical staff to their towns through accommodation initiatives and introducing potential doctors to sporting clubs and schools and all of those important things, to what extent do you, as an LHD, try and ensure that whatever is being offered by councils in that regard is being used in a way which is - or is being best used when lined up next to the equivalent services that might be offered by the LHD, say, to ensure there's no duplication or that you're not undermining the efforts of the local council unknowingly or the like?

A. Mmm.

Q. How does that work?

A. And it's been an evolving - that has been an evolving space. When I first started, there was a great deal of competition with various councils offering different incentives, if you like, to attract health workforce into their communities. I think that has settled to some degree since the introduction of the New South Wales rural health workforce incentive and the fact that we are now offering accommodation to the employees that we offer. But we have developed in collaboration with the local health advisory

1 committees a bit of a, I guess, roadmap, if you like, or  
2 a bit of a document about what communities can do, so that  
3 we don't get communities playing each other off against  
4 each other, and there is no doubt that the concierge role  
5 that councils play can make a difference in applicants  
6 choosing to go and live in a particular location.

7  
8 There was a case that one of the GPs told me about  
9 where they went to two towns and it was the - the town they  
10 chose to work in was the town where they were met, they  
11 were shown the schools, they were taken to lunch, and they  
12 were welcomed and they chose that town, and that was done  
13 by the council and the LHAC.

14  
15 Q. Do you see the LHD as having a role in trying to  
16 harness some of that concierging of services that might  
17 best be delivered by a local council, for its own  
18 purposes - that is, say, to recruit nursing workforce to  
19 hospitals and the like?

20 A. Yes. So there are two parts to the answer. So there  
21 is actually a pilot project that is being - we're  
22 participating in with regional New South Wales, where in  
23 Griffith and Corowa there's a concierge approach to  
24 workforce. It's been really, really successful.

25  
26 But with our overseas recruitment campaign, when we  
27 went to Ireland and the UK, and we've got 90-plus nurses  
28 coming in, we have engaged a person to do that concierge  
29 service for those new people coming in, because they're  
30 coming from another country, they meet them at the airport,  
31 they settle them in, they follow them up, and they're  
32 meeting - and they're talking with them before they get  
33 here. So we are trialling it.

34  
35 Q. Is that concierge service engaging with the local  
36 councils in the delivery of the service?

37 A. I do not know the answer to that. I would have to  
38 take that on notice.

39  
40 Q. While we're on the recruitment, in terms of  
41 recruitment of staff to the smaller hospitals, who is  
42 responsible for those recruitment efforts in terms of the  
43 filling out of the forms and making the phone calls and the  
44 like? Take as an example, Berrigan?

45 A. Yes. So we've made some significant changes in our  
46 recruitment model and I think it was since 2021. Early  
47 in - in late 2021/22, the whole dynamics changed. So

1 historically, the answer to your question would have been  
2 that the local facility manager or the local people manager  
3 of a service was wholly responsible for the recruitment  
4 process, except the transactional bit at the end, which  
5 involved issuing a contract and setting up that conduit  
6 with payroll.

7  
8 Q. So, just to use our Berrigan example, previously, the  
9 unit - the facility manager of Berrigan, would have needed  
10 to advertise for the job?

11 A. Yes.

12  
13 Q. Possibly using a centralised advertising platform?

14 A. Yes.

15  
16 Q. Received through that process, hopefully, some CVs and  
17 expressions of interest?

18 A. Yes.

19  
20 Q. They needed to sift through them, interview the  
21 candidates?

22 A. Yes.

23  
24 Q. Then take such steps as they needed to take in order  
25 to get a successful candidate on the ground and employed in  
26 Berrigan, which might involve dealing with some migration  
27 requirements?

28 A. Yes.

29  
30 Q. And might involve a level of - some concierge  
31 services?

32 A. Yes.

33  
34 Q. Possibly finding accommodation for the candidate?

35 A. Yes.

36  
37 Q. So all of that, under the old system, was being done  
38 individually by facility managers at different hospitals?

39 A. That is correct.

40  
41 Q. And just in those old days, was there any system in  
42 place for identifying whether the candidate who came  
43 second, perhaps, might be just as happy to work in Finley  
44 and might be referred to them as a possible recruit?

45 A. No. So there were significant delays in that process.

46  
47 Q. What were the sources of the delays?

1 A. As the workforce challenges started to impact, those  
2 facility managers started having to work clinical shifts.  
3 So that meant there was less time for them to do their  
4 administration and we started to see the recruitment time  
5 frames really go out in the wrong direction, and it was at  
6 a time when we had critical workforce shortages, and I use  
7 that - I don't use that phrase lightly, because we had,  
8 during that point in time, about 2020, right across the  
9 state in the small communities, the MPS sites, we had a lot  
10 of our nurses leave the system, and whether or not - and  
11 many of them were at the end of their working career and  
12 some of it was to do with COVID and they, you know, just  
13 felt burnt out, but we suddenly had a lot of people leave  
14 the system and then there wasn't a pipeline coming in, and  
15 so with our facility managers working on the floor, those  
16 time frames started to go out in the wrong direction, they  
17 started to lengthen, and we were losing candidates as well.  
18 And if there were good applicants that became second, they  
19 were lost to the system.  
20

21 So we set up a critical workforce task force. We  
22 pulled people offline and we had a list of 19 sites - I can  
23 still remember that figure, 19 - where we did end-to-end  
24 recruitment with them. We didn't take it over, it wasn't  
25 centralised, we did it with them. We did all of the  
26 administration components. The nurse manager still chose  
27 the candidates, but we employed two nurse managers, very  
28 experienced, could I say, who spoke with the applicants and  
29 matched them with where they thought they were best suited  
30 to work and enticed them to places they'd never heard of  
31 also. One was enticed to Deniliquin because of the ute  
32 muster.  
33

34 So that was a really important change for us, because  
35 then it meant that we did all of the transactional bits.  
36 Instead of doing them sequentially, we did them in tandem,  
37 and we reduced our time frames from 45 days plus down to  
38 31, 32 days, and we also --  
39

40 Q. Did it create economic efficiencies in the delivery of  
41 those recruitment processes as well?

42 A. Economic efficiencies? So we did actually have to put  
43 on a couple of extra staff to do some of that transactional  
44 work.  
45

46 Q. But if we look at - and again it may not have been  
47 measured - the two FTE worth of staff who you put on to do

- 1 that work, did that free up more than two FTE's worth of  
2 time --
- 3 A. Over time and agency.  
4
- 5 Q. -- in your community of hard-working facility managers  
6 and the like across the system?
- 7 A. Yes. Yes. I must say we haven't measured that, but  
8 that would be something, when we do the evaluation of our  
9 new supported recruitment that we call it, that we will  
10 definitely look to evaluate, because you could extrapolate  
11 also, if you got new people recruited, that you would  
12 reduce your overtime and your agency.  
13
- 14 Q. So reduced the turnaround on recruitment, which meant  
15 candidates who got offered another offer somewhere else  
16 were actually being captured because the window of time in  
17 which that other offer might come in was smaller --
- 18 A. Mmm.  
19
- 20 Q. -- potentially, with some efficiencies that are yet  
21 to be measured. What about an ability to potentially place  
22 a number of the applicants in other facilities around the  
23 LHD that the particular facilities manager - using our  
24 Berrigan example - might not have known was also looking  
25 for an RN or an EN?
- 26 A. Mmm.  
27
- 28 Q. Was that also something that was able to be gained  
29 through the centralisation --
- 30 A. Yes, absolutely.  
31
- 32 Q. -- at the LHD level?
- 33 A. yes, absolutely.  
34
- 35 Q. Have you found that that has worked?
- 36 A. Whilst it has worked, I think it's also accurate to  
37 say that there's still a big challenge in recruiting  
38 registered nurses with the skills and experience to work in  
39 those small hospitals. It is still very, very challenging,  
40 and that's to do with maldistribution. It's to do with  
41 whether people want to work in that environment as well.  
42
- 43 Q. One of the things you've told us about in your  
44 statement is the Virtual Nurse Assist program?
- 45 A. Yes.  
46
- 47 Q. Have you had any feedback on that program as to

1 whether it has been effective or it's seen as being useful  
2 by nurses who might not have thought about working in a  
3 remote area but have chosen to, despite that?

4 A. Yes, so we're - again, this was a deliberate effort to  
5 see if we could use early career nurses in our rural  
6 hospitals. The rule was previously that to work in an MPS  
7 you would need at least five years experience, and you  
8 would need to have experience working in an emergency  
9 department. So it was quite a change in the model for us  
10 to be able to allocate new graduate nurses to those  
11 facilities and make sure that they felt supported in the  
12 process, and clearly we didn't put them in charge in their  
13 first days there, but as time goes on, we've been able to  
14 support them.

15  
16 So the Virtual Nurse Assist, we set up with Royal  
17 Prince Alfred and with the backing of the Ministry of  
18 Health and is to be evaluated to see if it can be scaled in  
19 other places. So it's at that point now where we can start  
20 the evaluation.

21  
22 Q. So you haven't yet done a formal evaluation but do you  
23 have any sense of whether it's had an impact on recruitment  
24 and retention in those smaller hospital sites?

25 A. Yeah, absolutely. So the feedback - I mean, the  
26 reality is, it would be quite daunting going - particularly  
27 if you're coming from a bigger centre, you know,  
28 a metropolitan health service, and you're going to  
29 a facility where you're the only nurse, and the message  
30 that we give people now is you're never the only nurse  
31 because there's always someone that is there that can guide  
32 you through a process. If it's a retrieval, we'll help  
33 manage the patient, but if it's just support you need  
34 around, professionally, how to undertake the triage or how  
35 to undertake a particular procedure, we can assist you with  
36 that. It's like having a nurse in the other ward, except  
37 they're virtual.

38  
39 Q. Even if we start with measuring those things that  
40 are easy to measure, are measurements being made of the  
41 number of interactions that nurses in these small hospitals  
42 have --

43 A. Yes.

44  
45 Q. -- through the service and the like?

46 A. Yes, we're capturing the data.

47

1 Q. Again, to the extent you've had some visibility of the  
2 data, has there been a large uptake? Is it regularly used,  
3 the service?

4 A. Yes, it's regularly used. I think we heard Dean say  
5 he'd like them to use it more, and I think, like anything  
6 new, people need to feel empowered to use it no matter  
7 what. They don't need to think that it's because they  
8 don't know something, it might just be to double-check that  
9 they're on the right track.

10  
11 Q. You mentioned RPA a moment ago. Another key  
12 collaborator that you have as an operator of a regional LHD  
13 are metropolitan based hospitals?

14 A. Mmm.

15  
16 Q. You've given us a number of examples in your statement  
17 of ways in which that collaboration happens. Can I ask,  
18 how are those collaborations developed? Is there a formal  
19 process or is it history and ad hoc arrangements between  
20 clinicians who might have, say, been at university together  
21 or done their vocational training together who create these  
22 little alliances ultimately to the benefit of the LHD?

23 A. Mmm. It's a mixture of the two, actually, so --

24  
25 Q. In the former case, what are the formal structures  
26 that exist?

27 A. So there's some formal structures around trauma, so  
28 we're part of a trauma network. Wagga Wagga Base Hospital  
29 is a designated trauma centre, and in the network, we  
30 collaborate with St George as our trauma receipt hospital,  
31 and that is a formal network and there is collaboration and  
32 a formal process around that that happens.

33  
34 Q. And that's because someone at a ministry level has  
35 looked at - the LHD, the services available through Wagga  
36 Base, has looked at St George and said, "Here is a synergy  
37 that we need to formally put - implement"?

38 A. All of the rural/regional local health districts are  
39 linked --

40  
41 Q. To St George?

42 A. No, with a particular trauma unit, so it varies.  
43 Obstetrics is the other one, so there's a tiered obstetric  
44 network, where we are again part of a pathway with other  
45 services. So our referral hospital is actually the  
46 Canberra Hospital, so it's in ACT, but that is part of  
47 a tiered network. The other one is intensive care. So



1 once again, there's a tiered network, Griffith, Wagga Base  
2 Hospital and St Vincent's Hospital in Sydney. So.

3  
4 It's different hospitals for different craft groups.  
5 Those are statewide, formal pathways that have been  
6 established by the Ministry of Health and there are  
7 clinicians through the Agency for Clinical Innovation,  
8 clinical networks, that collaborate in those networks.

9  
10 Now, the other ones are the informal ones, and we  
11 heard about one of those I think when we were meeting with  
12 Professor Martin Jude, who was our neurologist at Wagga,  
13 and those particular informal arrangements are something  
14 that I'm really keen to tidy up, if you like.

15  
16 So with St Vincent's, we've got quite a lot of our  
17 clinicians who are linked with St Vincent's, and we do have  
18 an agreement with St Vincent's where we itemise those  
19 things. It's due for renewal, they've had a change of  
20 chief executive and I've made contact with the new chief  
21 executive, and we do have, together, a joint executive  
22 meeting once a year to go through our priorities of how  
23 that's working for us. So we have done that with  
24 St Vincent's, not so much with RPA, but I think there are  
25 opportunities to formalise those.

26  
27 Q. We've heard a little bit about the challenges  
28 presented to people within the LHD when it comes to  
29 accessing specialist services within the LHD in an  
30 outpatient setting or in private rooms even. Do you see  
31 that there might be benefit in a needs analysis being  
32 undertaken in respect of particular areas of specialisation  
33 at some level, perhaps above the LHD level at a ministry  
34 level, with a view to creating alliances between hospitals  
35 within your LHD and metro based hospitals, with a view to  
36 delivering public clinics through the hospital setting,  
37 public outpatient clinics?

38 A. Absolutely. That would be very helpful.

39  
40 Q. To what extent - that's okay, I'll move on. I will  
41 ask one more question. In relation to that, we've heard  
42 evidence from one of your colleagues about the issues of  
43 isolation experienced by clinicians in some smaller  
44 hospitals. Is there also a potential for a different type  
45 of isolation to be experienced by specialists practising  
46 out of a rural or regional LHD slightly removed from the  
47 larger centres which might have a much larger cluster of

1 those specialists working day-to-day, as, say, staff  
2 specialists?

3 A. Mmm, I think it's probably less of an issue, mainly  
4 because the Agency for Clinical Innovation have got some  
5 very sophisticated clinical networks and I know that a lot  
6 of our surgeons, physicians, and many of our specialty  
7 craft groups, actually participate in those clinical  
8 networks. They're very effective. They do all know each  
9 other, they share - you know, they talk about clinical  
10 variation, they look at innovation, they look at new  
11 models. So I actually think that those clinical networks  
12 that are run through the Agency for Clinical Innovation are  
13 very effective for our staff, our clinicians.

14  
15 Q. Can I come back to some of the workforce challenges.  
16 Do you have a copy of your statement handy?

17 A. I do.

18  
19 Q. Can I ask you to open up to page 27, paragraph 135.

20 A. 130?

21  
22 Q. 135.

23 A. Yes.

24  
25 Q. You tell us there about the financial incentives that  
26 have been introduced under NSW Health's Rural Health  
27 Workforce Incentive Scheme. Can I ask, has it been your  
28 experience that those incentives have been effective in  
29 reducing or at least easing some of the workforce  
30 challenges that you face in your LHD?

31 A. To some extent. They certainly have made  
32 a difference, and, you know, I was thinking of one facility  
33 manager recently up in, I think it was Hillston who has had  
34 a lot of success with the incentives.

35  
36 Where there is really very, very small communities  
37 with large vacancies, it remains hard to attract people,  
38 even with the incentive, and I think that is because people  
39 choose a job for more than the money, it's about the type  
40 of work that happens in that particular facility. It's  
41 mainly the very small multipurpose services where we have  
42 the biggest challenge.

43  
44 Q. Is there a challenge created by the scheme,  
45 particularly in a smaller community where there is perhaps  
46 at least a perception of a two-tier workforce, those who  
47 are receiving the benefits available through the scheme and

1 those who might have been working there for a longer time  
2 who are not?

3 A. So I've made a deliberate effort, and the scheme  
4 allows for me to apply the incentive to all the staff who  
5 work in that service.

6  
7 Q. Do you think that's important in the context --

8 A. Very, very important. It's incredibly important,  
9 because those people who have remained loyal to us are also  
10 being incentivised. So for all of the MPSs, our business  
11 rules and under the policy we can do this, so if one person  
12 comes in, in a hard to fill position, and gets the  
13 incentive, then the nurses all get the incentive.

14  
15 Q. You tell us also about the large number of leases of  
16 residential properties that have been taken by the LHD.  
17 That's in order to deal with a need to give accommodation  
18 or provide accommodation to potential recruits in order to  
19 secure them; is that right?

20 A. Yes, that's right.

21  
22 Q. But because otherwise accommodation within some of  
23 these communities would not be readily available to  
24 recruits?

25 A. That's right. We had an instance where we recruited  
26 a nurse to a particular middle-sized town and she arrived  
27 with family and children and was unable to find anywhere to  
28 live and we didn't have anywhere to offer and that person  
29 ended up moving to Wagga where they were able to find  
30 accommodation. So it was really then that we realised that  
31 we would need to do something to address the issue.

32  
33 Q. That no doubt comes at a substantial cost to the LHD?

34 A. It comes at a substantial cost.

35  
36 Q. But you, nevertheless, regard it as being necessary in  
37 the current climate to make some inroads --

38 A. Keep the service --

39  
40 Q. -- towards dealing with workforce challenges?

41 A. It's about keeping the services open.

42  
43 Q. Do you find that it's effective in that regard? Do  
44 you think the money is, to the extent it has to be spent,  
45 producing dividends in terms of your recruitment and  
46 retention efforts in these smaller towns?

47 A. It is very, very important, and it's the quality,

1 also, of the accommodation that we find to be able to  
2 provide to people, but it really does give us - so if  
3 somebody is looking to come to us and we offer three months  
4 accommodation, it is part of the incentive for them to  
5 come. If they can't find somewhere to live after that,  
6 they can stay on there, but we would charge a rental  
7 payment, yes.

8

9 Q. In the next paragraph or two paragraphs down, in fact,  
10 137, you tell us about the 182 beds that the district has  
11 as onsite accommodation, that some portion of it is not fit  
12 for purpose. Does that fall into the category of old  
13 nurses quarters on the one hand?

14 A. Yes, old nurses accommodation. Old nurses homes, yes.

15

16 Q. And some more recently stood-up more commodious  
17 accommodation that's described as pods?

18

19

20 Q. At the other end of the spectrum?

21

22

23 Q. But when you say some of the accommodation is not fit  
24 for purpose, what do you mean by that? I assume you're  
25 talking about the older accommodation?

26

27 A. Yeah, I am talking about the older accommodation. So  
28 most of our hospitals have got what we call the old nurses  
29 home, and bizarrely, nurses were once all women, for one  
30 thing, and they didn't seem to have families, and they were  
31 quite happy to share bathrooms. Well, that is no longer  
32 the case - any of those things. And so whilst that's  
33 essentially just a whole lot of very small single rooms  
34 with a shared kitchen and bathroom, that might be suitable  
35 for students that are just coming for a week to do  
36 a placement, they might be okay to do that, but it is  
37 certainly not fit for purpose.

38

39 Q. So that acts as a deterrent, as it were, for nurses  
40 who might otherwise, if the accommodation was a bit more  
41 comfortable, be willing to come and work in a particular  
42 facility?

43

44

45 Q. There's a priority, I assume, being given to the  
46 upgrading of those facilities?

47

48

1 Q. Where does the funding for that come from?

2 A. So all of the new infrastructure builds that I've  
3 undertaken since I've been chief executive, we've included  
4 onsite accommodation as part of the project, and that money  
5 for Narrandera, Leeton, Finley and West Wyalong is part of,  
6 again, a grant allocation through the Ministry of Health.

7  
8 Q. You told us a moment ago that it's not just about the  
9 money, and as you tell us in paragraph 138, the financial  
10 incentives are only part of the solution. When you say  
11 that addressing the problem comprehensively requires  
12 a holistic approach and following, could you just expand on  
13 that a little bit and tell us what you mean? What you have  
14 in mind?

15 A. Yes. So - which paragraph are you referring to?

16  
17 Q. Paragraph 138, you see at the foot of page 27.

18 A. Yeah. So this is about people's career pathways. And  
19 again, it goes to part of what we need to be able to  
20 provide to people is opportunities to grow and develop in  
21 their career. So if you took a job at one of our very  
22 small MPSs, then what else is there as part of your career  
23 development, is what I'm referring to there. So is there  
24 opportunity to train as a clinical nurse educator - and  
25 many of them do that - or to go into become a clinical  
26 nurse consultant in a particular specialty area?

27  
28 So there need to be more opportunities for people to  
29 be interested to come and - people might be very happy to  
30 work in a very small facility for a number of years but  
31 after that they might be looking at "Well, what's next?"

32  
33 Q. So how have you, as an LHD, sought to provide those  
34 opportunities within that perhaps very small setting like  
35 an MPS in Berrigan?

36 A. Well, we've been very fortunate where we have received  
37 nurse strategy funding to be able to provide a number of  
38 career opportunities for nurses, and I think we heard in  
39 some of the evidence about some new funding that we've got  
40 for rural generalist nurse practitioners. So there, again,  
41 over the last 10 years we've had investment around every  
42 facility now should have a clinical nurse educator on  
43 staff, so that people can learn and grow while they're  
44 working, and that they can have that continuous education  
45 built in to their facility where they work - they don't  
46 have to go to Wagga for it. And so we've been fortunate.  
47 So there are a number of programs that we've been funded

1 for that nurses can develop their careers.

2

3 Q. Shifting to the medical workforce, we've heard some  
4 evidence about GP VMOs with advanced skills feeling that  
5 the opportunities for them to exercise those skills and  
6 maintain them in smaller hospital settings are not there  
7 and perhaps could be?

8 A. Mmm.

9

10 Q. Is that something that is on the radar of the LHD?

11 A. Yeah, very much so. I mean it is --

12

13 Q. What is being done about it?

14 A. It's a delicate balance, isn't it, around - it's  
15 probably reasonably easy to do with anaesthetics, so we've  
16 got quite a lot of rural generalist anaesthetists who can  
17 support doing lists in some of our district hospitals; same  
18 with palliative care; same with ED, mental health,  
19 obstetrics also.

20

21 But I guess it's more around the proceduralists. We  
22 don't actually have that many proceduralists at the moment  
23 who have done, you know, that surgery component of their  
24 rural generalist training. I think what we need to think  
25 about is offering them opportunities - we do it for  
26 anaesthetics - to work across multiple sites rather than  
27 just a single site. So they might work in Tumut, they  
28 might work in Cootamundra and Temora doing lists, and they  
29 would need to be prepared to also travel, and from time to  
30 time go and work in Wagga to do, I guess, that more  
31 specialised work to keep their skills up to date.

32

33 MR MUSTON: I note the time, Commissioner, but I have one  
34 more question on this before I reach the end of the topic.

35

36 THE COMMISSIONER: Sure.

37

38 MR MUSTON: Q. To what extent, if any, does the block  
39 funded nature of the smaller hospital settings  
40 disincentivise an increase in the number of procedures that  
41 are delivered through that small hospital - that is to say,  
42 there's no obvious incentive to generating more activity  
43 through a block funded activity as compared with, say, an  
44 activity based funded facility?

45 A. I actually don't think that it's - the impact is  
46 material in our case. What is more of a hindrance is the  
47 ability to find the perioperative workforce that goes with

1 the surgery and that's mainly the nursing component. So we  
2 have a lot of pressure on our surgery wait list at Wagga,  
3 and we would like to do more work out in the district sites  
4 and we need to think about it differently in terms of  
5 probably having a team of nurses that go out to these sites  
6 and do the work with the surgeons and the local  
7 proceduralists, rather than expecting to be able to attract  
8 perioperative nurses, for example, to Tumut, where they  
9 might only get a list a month. So we need to look at it  
10 differently but the main hindrance at the moment is not the  
11 funding, it's actually the nursing workforce.

12  
13 MR MUSTON: I note the time. I don't think I will be too  
14 much longer but it may well be that we would benefit from  
15 a slightly shorter lunch break. I'm just mindful of the  
16 fact that --

17  
18 THE COMMISSIONER: 1.45?

19  
20 MR MUSTON: If that's convenient to everyone else, that's  
21 convenient to me.

22  
23 THE COMMISSIONER: All right. We will adjourn until 1.45.

24  
25 MR MUSTON: Q. I should make sure, is it convenient to  
26 you?

27 A. Yes.

28  
29 THE COMMISSIONER: 1.45, then. Thank you.

30  
31 **LUNCHEON ADJOURNMENT**

32  
33 THE COMMISSIONER: Yes, please continue.

34  
35 MR MUSTON: Q. Can I ask you some brief questions about  
36 the Murrumbidgee "Growing Our Own" strategy that you've  
37 told us about in your statement. It starts at  
38 paragraph 140, if that's useful. First question, how long  
39 has it been running for?

40 A. So the grow your own strategy has evolved over  
41 a period of time. It's been running probably for 10 years.

42  
43 Q. Has it been, to your observation, successful as  
44 a recruitment strategy?

45 A. It is the most successful recruitment strategy.

46  
47 Q. How has that success been measured? Is it just

1 tracking the --

2 A. It is really just tracking.

3

4 Q. -- the careers of the individuals that have been  
5 through it?

6 A. Tracking the vacancies, yes.

7

8 Q. But is it tracking the career progress of those  
9 individuals who have come out of the grow your own program?

10 A. Yes, that's right.

11

12 Q. When you say it has been the most successful program,  
13 do I take it that a very large proportion of those who  
14 you've grown yourself are still growing --

15 A. Yes.

16

17 Q. -- and living here?

18 A. Yes, that's right. So it's very hard for us to entice  
19 tree change, as they call it in the bush, people to come  
20 from the city to move to the rural areas, and there is  
21 a variety of reasons around that, around people's families  
22 and spouses and the like. But for those who have grown up  
23 here and have got their roots here and don't need to go  
24 away to do their education and training, they are more  
25 likely to stay.

26

27 So, for example, in our new graduate nursing program,  
28 even though some of those nurses will have come from other  
29 places, we have quite a high retention rate, and I don't  
30 know the exact figure, before you ask me - I'll have to  
31 take that on notice - but it sits around 85 per cent. So  
32 we do have a good retention rate for those new graduate  
33 nurses.

34

35 Q. An extension of that, I gather, is the school based  
36 training program that you've referred to in paragraph 144?

37 A. Yes.

38

39 Q. Newer but, so far, has it, to your observation, been  
40 effective?

41 A. It's been very effective, and I think probably the  
42 benefits of this program that you have seen we're doing in  
43 collaboration with Training Services NSW, who do fund  
44 a position also to assist in supporting those school  
45 students, it's a triple win, really, because, number one,  
46 they get to finish their higher school certificate, and  
47 many of them would probably not have gone on to do that.



1  
2           The second thing is that we pay them but we get  
3 another pair of hands in the workforce; but the third thing  
4 is, and you can see there in the stats, that 87 per cent of  
5 them are employed in qualified roles and 94 per cent of  
6 them have remained in the health industry. So it's very  
7 successful and very rewarding, I think. But those are  
8 actually quite young people who are in our health system  
9 and they do need quite a lot of nurturing and support.  
10 They're essentially school students who move into an adult  
11 workplace. So we need to make sure --  
12

13 Q.   These are school students who are doing year 11 and 12  
14 with a focus on vocational training rather than a progress  
15 towards university admission or the like; is that right?

16 A.   Yes, that's right. So they can do either assistant in  
17 nursing or allied health assistant, and they come out with  
18 a qualification from TAFE at the end of it, and that then  
19 contributes to any further studies that they might do in  
20 the health sector.  
21

22 Q.   How do you go about promoting that program throughout  
23 high schools within the wider LHD?

24 A.   So we've got two staff who work in the program and  
25 they go out to the local high schools during their career  
26 days and - but I think probably the work that they do with  
27 the career advisers in the schools and matching people up,  
28 and again, this is available in a range of high schools  
29 across the district, it's not just Wagga or Griffith. The  
30 students come from all over. And you can see that there's  
31 a high percentage of Indigenous students who also  
32 participate in the program - so 55 First Nations out of  
33 101 that we've graduated.  
34

35 Q.   Can I take you to a slightly different topic now and  
36 just ask you some questions about the virtual care services  
37 that are offered through some of your community hubs. You  
38 told us that there's a - we have been told, I should say,  
39 that there has been some form of evaluation carried out as  
40 to the effectiveness of that program. Are you aware of  
41 that evaluation?

42 A.   Are you referring to our remote medical consultations  
43 service?  
44

45 Q.   The remote medical consultation service is - you'd  
46 best explain to us what that one involves as compared with  
47 the virtual care service? Start with the first one, the

1 remote medical consultation?

2 A. Okay, because they're all run out of - they're all run  
3 out one hub, if we're talking about the same thing, the  
4 place we visited in Wagga Wagga.

5  
6 Q. So tell us first about the virtual care service?

7 A. Okay. So the virtual care service is a service that  
8 comprises of nurses and doctors who support emergency  
9 departments in the regional sites, or all the regional  
10 sites, actually, and so if a patient comes in that requires  
11 essentially a higher level of care than the team there are  
12 able to provide, then the nurse - they're critical care  
13 trained nurses, intensive care nurses, and they can patch  
14 in any of the medical professions that they need, but  
15 working alongside them are some emergency trained doctors  
16 who can help, in the first instance.

17  
18 Most of those patients are patients that are going to  
19 be retrieved or moved from that site to a higher level of  
20 care, and back in the regional hospital, there's a range of  
21 infrastructure there that supports good virtual care, so  
22 the pathology point of care testing, the ECG machine where  
23 we can transmit the ECG of the heart which can be reviewed  
24 by a cardiologist, and the camera system, and so all of  
25 that, I guess, is the infrastructure that enables the team  
26 back in the hub to be able to do the assessment.

27  
28 Q. So that program is slightly different but run out of  
29 the same place as the other, which deals more with the  
30 category 4 and 5 presentations in emergency --

31 A. Correct.

32  
33 Q. -- where a doctor, usually a GP, will be Zooming in  
34 remotely to the emergency department to provide that  
35 emergency treatment with the assistance of the nurses on  
36 the ground?

37 A. That's right, yeah.

38  
39 Q. In relation to that one, is there an evaluation  
40 process which is being undertaken in relation to that  
41 project?

42 A. Actually, all of it, if I could just say, because we  
43 run it as one service. The third component of the service,  
44 which we haven't talked about, though, is the patient  
45 transport, the non-emergency patient transport. It makes  
46 sense, in terms of efficiencies, to have the teams all  
47 joined and linked up because they can undertake mutual

1 duties that will enable all of that to come together,  
2 because if you've got a critical care patient, they're  
3 going to need an ambulance or a helicopter and so the teams  
4 work together.

5  
6 In terms of the evaluation, we've completed the scope  
7 now. We're just about to go out and that will be  
8 independently evaluated. So we've done our own data but  
9 we're now going to have that independently assessed.

10  
11 Q. What does your own data tell you about the success of  
12 the program relative to whatever metrics you're applying?

13 A. In terms of effectiveness from a clinical perspective,  
14 it's highly effective, and in terms of patient outcomes,  
15 every day makes a difference in terms of outcomes. I mean,  
16 those patients once upon a time would have undergone long  
17 waits, ambulance trips, without having that sort of urgent  
18 treatment done at the regional site. So the clinical  
19 benefits are there to be seen.

20  
21 What I'm really interested in is looking to see, in  
22 terms of efficiencies and cost, how we might be able to  
23 provide it more effectively. The issue is - around this  
24 particular model is that the dollars follow the patient.  
25 So the funding for the patient sits at the regional site,  
26 if they're in Berrigan, the funding is Berrigan, and so for  
27 us to run that service means that that is additional cost  
28 that doesn't fit into any funding envelope.

29  
30 Q. So the patient is in Berrigan, nurses and facility  
31 costs are Berrigan --

32 A. Yeah.

33  
34 Q. -- allocated costs but the cost of the doctor who is  
35 Zooming in from Wagga, possibly, or somewhere else --

36 A. The nurse.

37  
38 Q. -- is not a cost which is picked up as part of the  
39 allocation of funds to Berrigan?

40 A. It doesn't count as activity and it doesn't fit into  
41 any of our funding envelopes.

42  
43 Q. That probably brings us nicely to a comment you make  
44 at paragraph 124 of your statement, that the current  
45 funding model doesn't include incentivisation of funding  
46 for health promotion prevention because it's very volume  
47 based. Could you just explain ways in which you think the

1 system or the funding model could be adjusted to better  
2 incentivise funding for health promotion and prevention?

3 A. It's a very wicked problem because, in actual fact,  
4 when the board and the executive and the staff are doing  
5 our strategic plan, this was a conversation that we asked  
6 many people, including the Commonwealth Government, because  
7 the reality is that the primary health network is not  
8 really funded either to do preventative care and, you know,  
9 we are obviously funded to run and operate hospitals and  
10 provide community services, but they're largely around case  
11 management of difficult patients. So who is responsible  
12 for preventative care?  
13

14 It's probably more noticeable in the regional and  
15 rural areas because of our levels of socioeconomic  
16 disadvantage, and most, or all of our local government  
17 areas have got a high level of socioeconomic disadvantage  
18 and health literacy is low. So the lifestyle decisions  
19 that people make don't necessarily contribute to good  
20 health outcomes, and we've heard about some of the issues  
21 with other people giving evidence.  
22

23 So how do we fund preventative care and how do we fund  
24 healthy ageing is a really challenging issue, and  
25 I actually don't really know the answer to it.  
26

27 THE COMMISSIONER: Q. What was the conversation with the  
28 Commonwealth Government about this?

29 A. Well, I guess to some extent, primary health networks  
30 have got flexible funding, and so - and every, I guess,  
31 general practitioner can do opportunistic preventative  
32 care, when you come in and you want to have your work  
33 certificate, but you end up having your blood pressure  
34 checked. So that was essentially the kind of information  
35 that we received.  
36

37 But I do think that there needs --  
38

39 Q. Sorry, does that mean the Commonwealth said, "Look,  
40 GPs can do this as part of doing an item on the MBS"?

41 A. (Witness nods).  
42

43 MR MUSTON: Q. Would it be right that preventative  
44 health care probably fits into a number of different  
45 categories as well - there's lifestyle diversion, eat well,  
46 exercise, smoking cessation, all of those sorts of aspects  
47 of preventative health care?

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THE COMMISSIONER: Taking blood pressure.

MR MUSTON: Well, that might fall into the second category.

THE COMMISSIONER: It sounds like the lowest level of preventative care, but anyway, it's probably essential.

MR MUSTON: Q. The first category is attempts that can be made to adjust the way people live their lives so as to avoid the development of chronic illness and its increasing burden?

A. (Witness nods).

Q. There might be a question about where the fund - what the funding source for that should be but it's critically important, is it not, that it happens? Wear sun cream, for example, all sorts of campaigns that try to prevent people from getting sick in the first place?

A. It probably needs to happen across all three tiers of government, to be fair. So councils can play quite a big role in environmental health and preventative health. So walking paths, art in the community, all those things are actually connection points for people who live in the community, they are very, very important in terms of wellness. People go out and walk their dogs when there are great walking paths, parks, those sorts of things, for children, and to be fair, NSW Health does invest in health prevention.

There's quite a number of strategies around childhood obesity. We've got a small team who work in health prevention and development, so they work in preschools and also in schools around healthy eating, and there's also investment at a statewide level now in the Brighter Beginnings, which is linked with the First 2000 Days, where our nurses are going to go into schools and assess children for their development in Murrumbidgee.

Q. Have you seen benefit through The First 2000 Days program across your LHD?

A. Early days, early days yet, yeah. So it's a long-term strategy, yeah.

Q. And I think it was a premier's priority, at least one premier ago?

- 1 A. (Witness nods).  
2  
3 Q. I'm not sure whether it is still a premier's priority,  
4 but is it still a program that is being funded through --  
5 A. Yes.  
6  
7 Q. -- at least the LHD in your district?  
8 A. Yes. The Ministry of Health are still funding the  
9 program and it still occurs, and again, it's another  
10 long-term investment, I think, but it probably needs - it  
11 needs all lots of - it needs lots of people to intersect  
12 with a strategy like that for it to be successful.  
13  
14 Q. A whole of government issue?  
15 A. Yeah.  
16  
17 Q. Are you aware of whether other branches of government  
18 within your district who you intersect with are continuing  
19 to fund and deliver the projects that were broadly brought  
20 under that First 2000 Days banner?  
21 A. Other government agencies?  
22  
23 Q. Yes.  
24 A. Yes, so definitely schools are one that I know about.  
25 I probably can't talk about others. Yeah, don't have a lot  
26 of visibility, although I have to say I do attend regional  
27 New South Wales meetings cluster, regional meetings with  
28 all of my counterparts, and we do talk about these sorts of  
29 strategies at a whole of government level.  
30  
31 Q. I think you've mentioned in an earlier answer issues  
32 around funding cycles.  
33 A. Mmm.  
34  
35 Q. The funding cycle that you work to at the moment is an  
36 annual funding cycle?  
37 A. That's right.  
38  
39 Q. And that present some challenges for you and the LHD  
40 in terms of rolling out programs over a longer period than  
41 12 months?  
42 A. That's right.  
43  
44 Q. How do those challenges manifest themselves in a  
45 practical way within the LHD?  
46 A. So I guess if we think about the funding cycle, if  
47 we're going to - if we're going to implement something new,

1 it's going to take a level of time to appoint the project  
2 team, develop up, review the data, work out what the  
3 solution is, and if you've only got one year's worth of  
4 funding and you get partially along that track, but then,  
5 at the end of the financial year, that funding finishes and  
6 it cannot be rolled over, so then you're partially way  
7 through that work, so then you've got the decision as  
8 a chief executive, which is very challenging, what do I do?  
9 I don't have funding for that work anymore. Is that  
10 something that we're now going to stop or continue? So  
11 that's just an example of things that happen from time to  
12 time.

13

14 Q. Is that in part a function of the fact that the budget  
15 that you can rely on getting year in, year out, is only  
16 just or perhaps not quite enough to deliver the essential  
17 services that the LHD has to deliver in an acute manner  
18 year in, year out, and so the funding for these projects is  
19 something that needs to be either separately allocated as  
20 a bonus to the budget or, alternatively, found as some  
21 spare money somewhere that you manage to squeeze out of  
22 something else?

23 A. That would be correct, because there's certainly not  
24 surplus in my budget at the end of the financial year.

25

26 Q. Would a standing budgetary item for research and  
27 development, innovation, which year in, year out, you know  
28 will always be available, be something which would be  
29 useful from the perspective of the LHD?

30 A. Yes.

31

32 Q. Which could be spent at your discretion on the advice  
33 of clinicians within the area and perhaps in consultation  
34 with the ACI?

35 A. Yes, it would be, and happy to acquit it in all the  
36 proper ways, but yes, it would be helpful.

37

38 Q. Can I ask you a very quick question about new builds,  
39 of which there seem to have been a lot in your LHD over the  
40 last few years?

41 A. Yes, we are fortunate.

42

43 Q. You indicate in paragraph 128 of your statement that  
44 there may be opportunities for greater transparency around  
45 the funding allocated to new builds. What did you have in  
46 mind when you talk about transparency in the funding? Is  
47 it decision-making around what to fund or decision-making

1 around how the funding is to be spent within a particular -  
2 at a particular site?

3 A. It's probably about the recurrent budget going forward  
4 at the completion of the build. So the project funding  
5 covers the commissioning and all the elements of building  
6 the building, but there are issues around the whole of  
7 life maintenance cost of new builds that under activity  
8 based funding - if you take, for example, the Wagga Wagga  
9 stage 3, that was - we actually didn't have a building that  
10 provided that before, it was a whole lot of leased premises  
11 all over town with those clinics and it was all brought  
12 together under one new roof. So it's activity base funded,  
13 but the costs of the utilities and just cleaning it, and  
14 obviously the ICT and all those components, were quite  
15 significant and it's really hard, I think, for us to be  
16 able to quantify what that's going to look like and make  
17 sure that in the first years that we're given some  
18 assistance with that.

19  
20 I think, to be fair, there's a lot of improvement that  
21 has happened since the Wagga stage 3, and now that  
22 financial impact statement is being re-looked at. It used  
23 to be quite old, so by the time you built your building,  
24 it's, you know, three years down the track and the whole  
25 world's moved on, essentially. So now we're redoing the  
26 financial impact statement for - we've got Griffith that's  
27 going to be commissioned next year. It's roughly twice the  
28 size of the existing hospital, it's got some new services  
29 so we need to redo that financial impact statement to have  
30 a really clear picture of the budget.

31  
32 Q. So is the short point you get allocated funding for  
33 the actual physical build and commissioning of the  
34 hospital; once it's built, a nice big new hospital incurs  
35 a whole lot of costs associated with its operation,  
36 including cleaning costs and staffing costs and the like,  
37 which increase doesn't necessarily reflect itself in an  
38 increase in activity?

39 A. Correct.

40  
41 Q. And under the activity based funding model, the  
42 activity remains perhaps the same?

43 A. Similar.

44  
45 Q. The funding through that model remains the same, but  
46 it has to be spread thinner because there's a whole lot of  
47 additional let 's call them fixed costs associated with



1 running the larger, newer hospital?

2 A. Correct. And just for the record, I understand that  
3 there is now funding that is allocated in the early days to  
4 help with that, so - yeah.

5

6 Q. So the transparency that you refer to, is it that you  
7 think perhaps better - more careful consideration should be  
8 given from a ministry perspective to identifying what the  
9 real costs, recurring costs of running the new facility  
10 are?

11 A. Yes.

12

13 Q. And ensuring that, in formulating the LHD's budget,  
14 that increase in the costs, which costs don't generate  
15 further activity, are brought to account --

16 A. Exactly.

17

18 Q. -- in an appropriate way?

19 A. Exactly.

20

21 Q. In terms of decisions around whether to open a new  
22 hospital or refurb a particular hospital, those decisions  
23 often are largely political?

24 A. No, I wouldn't agree with that. So when funding is  
25 allocated, there's a whole planning process that you go  
26 through. So step 1 is the clinical service plan. Then  
27 step 2 is how can we deliver on that clinical service plan.

28

29 Q. Maybe we're at cross-purposes.

30 A. Sorry.

31

32 Q. If I take it back a step, funding has not yet been  
33 allocated?

34 A. Okay.

35

36 Q. A decision is made. There is funding which government  
37 or a prospective government wants to allocate to  
38 a hospital, say - I won't name one - a hospital in your  
39 area?

40 A. Doesn't matter.

41

42 Q. And that becomes, say, an election promise. Is there  
43 any interaction between those who are making those sorts of  
44 promises and you, as the CE of the LHD, about whether,  
45 having regard to your acute and detailed knowledge of the  
46 needs of your LHD, the particular hospital which might be  
47 the subject of a promise is the best one to be allocating

1 rebuild money to?

2 A. So we have our strategic asset management plan, SAMP.  
3 There's an AMP, too, but we won't go there, that's about  
4 maintenance. And so in the strategic asset management  
5 plan, we have the opportunities - the opportunity to  
6 prioritise those that we believe are of the greatest need  
7 for us in our district, and that is usually to do with the  
8 functionality of a service.

9

10 If the functional layout of the facility means that  
11 it's impacting on the clinical service delivery, that then  
12 gets a higher weighting in terms of how we work out our  
13 priorities. And when we work out our priorities, we also  
14 at that time work out a total estimated cost, but it is an  
15 estimated cost, and we do a clinical services plan as well.  
16 So those then sit there, yeah.

17

18 Q. In the time that you've been in the job, has it been  
19 your observation that decisions around which hospitals  
20 within your region to refurb or rebuild have aligned nicely  
21 with the prioritisation of --

22 A. Mostly.

23

24 Q. In the SAM schedule?

25 A. SAMP.

26

27 Q. SAMP schedule?

28 A. Mostly.

29

30 Q. Can I ask you a couple of questions about some  
31 cross-border challenges. We've heard a reasonable amount  
32 about the issues that your LHD faces as a result of its  
33 being hard up against the border of a territory and another  
34 state.

35 A. Mmm-hmm.

36

37 Q. Patients from within the LHD flow between those  
38 borders. Is that something that creates any particular  
39 challenges or compromises the LHD's ability to deliver on  
40 the health needs of its community in any particular way, as  
41 you see it?

42 A. There are many challenges. So your question is?

43

44 Q. What are the real challenges in terms of the  
45 cross-border issues? What is it about the cross-border  
46 arrangements that makes it harder for the LHD to deliver on  
47 the health needs of its population?

1 A. I think I'll start with saying that people who live on  
2 the border, if we take the border with Victoria, because  
3 one-third of our hospitals actually flow into Victoria,  
4 they essentially access most of their services, their  
5 shopping, their football, whatever, in Victoria. You could  
6 say that they're largely living more a Victorian life than  
7 a Sydney life. And so, though, when it comes to provision  
8 the health services, sometimes it seems like the border is  
9 like a barrier and people have this expectation that we  
10 have to duplicate the services on the other side of the  
11 border, when there's a hospital that might just be, you  
12 know, 15 kilometres across the border and down the road.  
13

14 So that's really challenging, and along our side of  
15 the Victorian border is quite rural and a long way from  
16 Sydney and a long way from Wagga and so the services out  
17 there and the population out there is quite small, and so  
18 the services are largely multipurpose services.  
19

20 For those people who need a high level of care, they  
21 will have to go to Victoria, and that then opens up a whole  
22 lot of problems around transfer of information. The  
23 retrieval services work absolutely beautifully, as does the  
24 ambulance service, because we've worked that out, and when  
25 somebody rings an ambulance, the closest ambulance comes;  
26 whether it is Victoria or New South Wales, they get  
27 a response. And the retrieval service in Victoria are  
28 fantastic to work with.  
29

30 So we've worked some of it out. But there are  
31 complexities around accessing different community services  
32 when people are discharged. Access around information flow  
33 and handover sometimes can be clunky.  
34

35 We've obviously got Albury Base Hospital that's within  
36 our footprint and we have - I talk to the CEO of Albury  
37 Base Hospital every fortnight, early in the morning. We  
38 have a formal catch up and we talk about issues and we try  
39 and sort them out from an operational perspective, because  
40 Albury Base Hospital is operated through the Victorian  
41 Department of Health, and we have joined executive meetings  
42 as well, because some of those operational flows and some  
43 of those nuances around the services can be worked out more  
44 effectively at a local level than going back through our  
45 various departments.  
46

47 Q. Is there anything that you think could be done at

1 a ministry level in both New South Wales and Victoria to  
2 iron out some of those wrinkles that you have to deal with?

3 A. We've got cross-border commissioners in the mix as  
4 well, also. Look, I don't think I can answer that question  
5 because I don't have enough visibility about what our  
6 various departments - and what that interaction looks like.

7  
8 Q. Can I ask you to have a look at paragraph 109 of your  
9 statement. Could you tell us, in what ways do you think  
10 the future service models might better be aligned to  
11 address the health needs of the community in the ways in  
12 which you have described in that paragraph, in a practical  
13 sense? Conceptually, what you have said in 109 makes  
14 perfect sense, but in a practical sense, how does that work  
15 on the ground or could it work on the ground?

16 A. This might be the magic wand question.

17  
18 Q. Well, I'm very happy to pass you the wand or, the  
19 Commissioner likes the wand, I prefer the genie's bottle,  
20 but we'll give you both and you can make your own choice.

21 A. I think that because we have the historical way of  
22 providing services to the community, the local health  
23 districts are doing what we did in 1980, you know, we're  
24 still running an ED, we're still running a hospital, and  
25 we've always had aged care, and now we've morphed into an  
26 MPS, and that works well.

27  
28 But the needs of the population have changed but our  
29 models haven't, and neither has our workforce really,  
30 either, because we're still straining to provide the  
31 workforce for the hospital when the needs are actually more  
32 in the primary care space, and so that basically means that  
33 the community health needs are not necessarily being met in  
34 the model that we're providing, even though there's a lot  
35 of resources in the town.

36  
37 So it goes back to how could we use those resources  
38 and the resources that are coming from councils, the  
39 resources that are coming from the primary health network,  
40 all with varying different policy drivers and different  
41 funding sources and slightly different agendas, but they're  
42 all there in the town. And some of the needs are also in  
43 terms of social needs, because we've got an ageing  
44 population, we've got frail elderly there on their own,  
45 aged care packages might not be able to deliver because  
46 there's not the service provider nearby.

1           So we've got a whole lot of - a collision of things  
2 and resources that aren't pulled together. And so if we  
3 really want to seriously look at meeting the needs of that  
4 population, then we need to look at the models first.

5  
6           Q.    If you were given all of those funds from the various  
7 disparate sources that find their way one way or the other  
8 into the delivery of health care within the community and  
9 they were dropped into a single budget under your control,  
10 how would you go about designing the best model for the  
11 delivery of health care in a community, accepting that each  
12 community will have a slightly different model which will  
13 work for it, but what would your approach be?

14          A.    Well, it would be, you know, obviously the health  
15 needs assessment, so you work out what people need, and  
16 then you work out what the workforce is. If you recall  
17 earlier, I said we're having trouble attracting people to  
18 work in our current model, but if you can imagine that all  
19 of the workforce comes together so that instead of the  
20 social isolation within their profession now they've got  
21 colleagues, and you've got a cohort of people that are  
22 really there for one purpose, which is to develop - to  
23 deliver health and social needs to their community, and  
24 you've got a cohort of people with one purpose, and you  
25 allocate your workforce in accordance with the needs of the  
26 community. And it's always going to be in those  
27 communities about healthy ageing, how you support people to  
28 stay at home, you know, if you've got a social care  
29 provider in the mix then that can be worked through.  
30 There's mental health issues, there's a lot of depression  
31 attached with being on your own and ageing. There's  
32 youth - so there's a whole range of things, but I could  
33 imagine that it would be easier to attract people to work  
34 in a collaborative integrated model than in the current  
35 models that we're trying to fill the gaps with.

36  
37          THE COMMISSIONER:   Q.   Working out what people need, some  
38 of it you're going to know?

39          A.    Yes.

40  
41          Q.    You're just going to know, and other parts of what are  
42 the health needs of your population, really good data is  
43 going to help?

44          A.    Yes. I think so. The health needs assessments that  
45 are undertaken by the primary health network include things  
46 like access to internet, and all those things are actually  
47 really important, and then if you combine that with, you

1 know, the ABS data and our health data, you've got quite  
2 a good picture, I think, of local communities.

3  
4 MR MUSTON: Q. So is the starting point in the perfect  
5 world, you sit down with all of the money that's available,  
6 potentially in a particular community, you take your health  
7 needs, and you look to build as an integrated model the  
8 best healthcare service for the delivery of health care in  
9 that community, utilising the funds that are available in  
10 the most effective way?

11 A. Mmm. And, you know, I think, though, we need to  
12 understand that that wouldn't be continuation of what we're  
13 currently doing, it would look different.

14  
15 Q. It would, for example, remove the oft-heard sort of  
16 suggestion that delivery of one part of - that one form of  
17 health care is the responsibility of one entity and not the  
18 responsibility of another, for example?

19 A. Yes.

20  
21 Q. It's the collective responsibility of the group to  
22 deliver for the health needs and their pooled resources  
23 would be used for that purpose?

24 A. Mmm. I think at the core of that model would be aged  
25 care, some sort of provision of aged care, whether it's  
26 residential or community based, and also some level of  
27 primary care and urgent care, because the majority of the  
28 work that's being done in our emergency departments is  
29 actually urgent care, and urgent care and primary care can  
30 be done by a general practitioner and nurse practitioner.

31  
32 Q. And urgent care, as distinct from what might be  
33 regarded as genuine acute care delivered through an  
34 emergency setting?

35 A. Yes. And then, you know, if we've got our then bigger  
36 towns with their emergency departments, they're going to  
37 have the volume of activity to support the specialist  
38 workforce that we need in there as well, so then you have  
39 your busy and vibrant EDs that are not so far away and you  
40 have your urgent care and your aged care services  
41 supporting the community, along with your integrated allied  
42 health team supporting healthy ageing and chronic disease  
43 management.

44  
45 Q. Can I ask you to put the wand down for a minute. I'm  
46 going to ask you some questions about procurement.

47 A. Right. Sure. That's a disappointment.

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THE COMMISSIONER: Mr Gyles will be listening on the live stream.

MR MUSTON: Q. If you feel the need to pick up the wand at any point while talking about procurement, let us know. Can I ask you to turn to paragraph 117 of your statement where you suggest that, from a district point of view, it would be nice to see greater transparency around market testing of what takes place through HealthShare. I assume when you refer to that market testing, that's of the shared services - linen, food and transactional services, for example?

A. Yeah, and look, having so many hospitals, the cooking, cleaning and support services are done extraordinarily well by HealthShare, but they're also quite costly and contribute quite a significant part of the budget over which we don't have any control, if you like, together with, you know, IT and the support service with the hospital, those are pass-through costs. Then we've got the staffing and the activity, so there's not - there's no margins, really, in those small sites around efficiencies, so --

Q. Since 2018 you've been a director of HealthShare?

A. On their board.

Q. I see. On the board of HealthShare?

A. Yes.

Q. Can I ask, in that time, are you aware of anything having been done by HealthShare to increase the level of transparency that's provided to LHDs around these sort of issues?

A. Yes.

Q. What has been done?

A. They have done a lot of work around market testing and working out, I guess, how they figure in the market. It's such a big service and it's very hard to find a market comparator to compare HealthShare with. You know, you've got various other cleaning agencies, if you like, that look after hotels, but it's very difficult to undertake a comparison with a hospital environment. But they have done a lot of work around that market testing.

Q. Do you know what that work has involved?

1 A. I couldn't give you the details, I was not privy to  
2 those as a board member. Yeah.

3  
4 Q. You referred to the pass-through nature of the costs  
5 of some of those services. You would be aware, on the  
6 board of HealthShare, that they have KPIs that include an  
7 obligation to deliver within a budget?

8 A. Yes.

9  
10 Q. As do you as an LHD. Is there an issue associated  
11 with the pass-through nature of the costs that the  
12 incentive to find efficiencies and savings within the  
13 delivery of those services doesn't rest with HealthShare,  
14 if they, responsible for the delivery of those services,  
15 can then pass on the full costs of them to the LHDs and,  
16 nevertheless, still potentially bring themselves within  
17 their budget?

18 A. So the reality is what you're saying is correct, but  
19 I want to put a caveat on it, which is that HealthShare  
20 work in partnership with the local health districts in a  
21 true way, and we have raised with them that we would like  
22 to look at some, I guess, greater efficiencies in some of  
23 the support service models that we have, and it's always  
24 the small sites where we're talking about a labour market,  
25 really, and the costs around the cooking and cleaning are  
26 largely around the labour, and so we're very keen to engage  
27 with them to do some work around what would a more  
28 efficient model look like, how could we rearrange it, and  
29 they're very eager and keen to do that. So I just want to  
30 say that that's important and we're about to start doing  
31 that work. Yes.

32  
33 Q. In relation to the shared services that are not  
34 strictly volume based - when I say "volume based", food  
35 obviously is a volume based service; linen is a volume  
36 based service - but some of the others like the  
37 transactional and payroll services are not volume based?

38 A. Some are, some aren't.

39  
40 Q. They might be charged in a volume based way but it's  
41 not necessarily clear that there is a connection between  
42 the volume and the actual cost to deliver per item, as it  
43 were, per staff member, for their payroll, for example?

44 A. Yes.

45  
46 Q. Do you think there might be utility in having some of  
47 those less volume based services not passed through as



1 a cost but, rather, provided by HealthShare through  
2 a budget delivered to HealthShare within which it has to  
3 deliver that service system-wide - payroll, for example?

4 A. Yes - well, for me it would make my life so much  
5 easier, and I'm just trying to think of, then, where are  
6 the opportunities for the improvement? So the  
7 opportunities for improvement would then sit with  
8 HealthShare, yeah.

9

10 Q. Well, at the moment HealthShare has full control over  
11 the manner in which those services are delivered?

12 A. Yeah.

13

14 Q. HealthShare delivers those services and then works out  
15 a way, as we understand it, of sharing the total cost of  
16 delivering those services to the system across the system  
17 by, in the case of payroll, say, dividing the total cost by  
18 the number of employees on the payroll and divvying that up  
19 between LHDs on a per employee basis?

20 A. Yeah, there would need to be a partnership, because -  
21 I'll just use an example.

22

23 Q. Yes.

24 A. If a people manager hasn't finalised their time  
25 sheets, and then that has to be done manually and there's -  
26 it costs more, essentially, if we don't do that right,  
27 there's an imperative back to the local health district to  
28 fix that problem because that's not the right thing. If  
29 you funded HealthShare, the districts would have to be  
30 a partner and make sure that we kept our end of the bargain  
31 as well.

32

33 Q. Is the answer to that, in terms of efficiencies, which  
34 can only be achieved through the actions of the LHDs, are  
35 there to be gained, then the financial risk of failing to  
36 gain those efficiencies might fairly rest with the LHD?

37 A. Yes.

38

39 Q. To use your example, if you don't get your payroll  
40 forms in on time, there may be some financial penalty to  
41 the LHD?

42 A. Yes.

43

44 Q. But if you get your payrolls in on time then the risks  
45 associated with any inefficiencies in the dealing with  
46 those timely delivered forms would rest with HealthShare --

47 A. That would work.

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Q. -- who has full control over the way in which those services are delivered?

A. Yes, that would work.

Q. You tell us at paragraph 118 about the potential benefits of a Wagga Wagga regional distribution centre.

A. Mmm.

Q. Probably I can be brief with that, but is the issue that you are pointing to there that - does it turn on the fact that the costs of obtaining items through HealthShare in Wagga Wagga is greater than the costs at the moment of obtaining the same items through HealthShare in the metro LHDs because of the shipping costs?

A. The transport cost, yeah. And I guess the inefficiencies around the logistics. Every time a facility rings up and makes an order outside of their schedule, they have to dispatch it on a truck with that box of whatever it is. It might only be a very small amount, but it's got to come all the way from Sydney, and we pay the price for that. And you might say, "Well, that facility should have ordered it on the day they were meant to", but it doesn't always work out like that in life, and also, the volumes that our small sites need are often less than what they can order from HealthShare and then they end up with a large amount of stock that could potentially be wasted. So a local distribution centre, of which there is recognition from HealthShare, to be honest, would be able to, I guess, help with the logistics and some of those transport costs and reduce waste.

Q. At the moment, is there any financial adjustment made to your budget on account of the transport costs that you incur in purchasing things from the Sydney warehouse?

A. No, no.

Q. So it's right, is it, that, in effect, the cost to Murrumbidgee LHD of purchasing items, which might be available through a statewide contract at a uniform price, is, in reality, a bit higher than the cost to a metro LHD that's not having to pay that transport cost?

A. You could say that.

Q. As a matter of practical reality. I understand the dollar on the sticker is the same.

A. Yes. That's right. The dollar - yeah, the base price

1 is the same. I think you probably - and it is complicated  
2 because back in the days when we were doing our own  
3 ordering, we probably paid a higher base price for the  
4 items than the big statewide contract, so I guess the  
5 wash-up in the economics of all of this is hard to  
6 understand, but I know from a practical perspective that we  
7 are paying more in the transport costs year on year on that  
8 base price.

9  
10 Q. Can I ask you quickly about paragraph 119 where you  
11 say "improved pharmaceutical inventory management system  
12 would be an opportunity for the district"? Could you just  
13 explain briefly how that opportunity might work?

14 A. Yes. So we know about DeliverEASE and the success of  
15 DeliverEASE. DeliverEASE does not include pharmacy items  
16 at the moment, and in the procurement reform, where they've  
17 got procure-to-pay coming up in the reform process, it's  
18 going to tidy up that whole back end of the pharmacy, which  
19 is all very manual and labour intensive at the moment in  
20 matching tax invoices and batches off to HealthShare for  
21 payment. So that's all going to get tidied up and we  
22 welcome that when it comes along, and our pharmacists are  
23 already engaged in that change process.

24  
25 The bit that I'm still keen to see is the inventory  
26 management, and it's fantastic that there has been  
27 a statewide formulary developed, because that then gives us  
28 better buying power. It's also good from a clinician  
29 perspective. So the formulary has been fantastic, and  
30 a shout out to the rurals, because we did a rural one  
31 first, off our own back a number of years ago. But the  
32 inventory management is still very labour intensive.  
33 There's a system called i.Pharmacy, but it doesn't have any  
34 interface with the payments system and the ordering system,  
35 which all has to be done through different iterations. So  
36 it would be really good to see something like DeliverEASE  
37 for the inventory management.

38  
39 Q. Under the current arrangements do you have an ability  
40 to, say, look at a particular medication that you might  
41 have sitting in the pharmacy at Berrigan and recognise that  
42 it's not often used and about to go out of date so perhaps  
43 we should ship it up to Wagga where they use it more  
44 frequently?

45 A. No.

46  
47 Q. And when you talk about improvements in the inventory

- 1 management of pharmaceuticals is that --  
2 A. Yes.  
3  
4 Q. -- one of many things that you think might be a good  
5 feature?  
6 A. Yes.  
7  
8 Q. It'd prevent wastage and also in times of surge enable  
9 you to make sure you are --  
10 A. Absolutely.  
11  
12 Q. -- able to find every last box of that particular  
13 medication that you might need?  
14 A. Absolutely. And every time there's a new contract  
15 let, they've got to go in manually and sort of input that  
16 data into the iProcurement system, the i.Pharmacy system,  
17 so, yes, possible opportunities there.  
18  
19 Q. Can I just change subjects a little bit to service  
20 planning. At a general level, how are decisions made in  
21 the context of, say, a rebuild or a refurb, like in Finley,  
22 as I understand one is on the cards?  
23 A. Mmm-hmm.  
24  
25 Q. How are decisions made about which services to deliver  
26 through the budget that has been allocated for the refurb  
27 of that hospital? So, that is, how are decisions made  
28 about whether an operating theatre should be included as  
29 part of that rebuild as opposed to a renal chair or - they  
30 might be poor examples but hopefully you get my drift.  
31 A. Yes, I do. I do understand. Those decisions should  
32 be made when we do the clinical service plan, before we get  
33 into the infrastructure design, because if the activity  
34 isn't there for renal, then that would be articulated in  
35 the clinical service plan.  
36  
37 Likewise with operating theatres, if, when they looked  
38 at the activity in that particular region, it was  
39 determined that there was insufficient activity to support  
40 perioperative services and that people from that region  
41 would be better off accessing them from another centre,  
42 that should be articulated and must be articulated in the  
43 plan, because the clinical services plan is what informs  
44 the build.  
45  
46 Q. It should inform the build. In your experience over  
47 the last decade, has it always informed decisions around

1 the build?

2 A. It has largely, absolutely. Yes.

3

4 Q. And are those assessments made, and I gather from an  
5 answer you made a moment ago that they are, but to confirm,  
6 those assessment are made in a systemic way so that you  
7 look - dealing with, say, renal chairs, you look at where  
8 renal chairs are in and around the facility in question,  
9 with a view to determining whether adding one in that  
10 particular facility would be a necessary and appropriate  
11 thing, having regard to the needs of the community as  
12 they've been assessed for that service?

13 A. There's software that looks at population projection  
14 increases, and often it's the population figures that we  
15 have the most disagreement with, with local council,  
16 actually. And I think that's generally across the board  
17 with many things and they count their population slightly  
18 differently than the ABS, because they look at development  
19 applications in the pipeline, whereas the bureau of  
20 statistics doesn't.

21

22 So it gets put through quite a complex assessment, and  
23 it would determine - it will spit out what the projected  
24 activity would be in 10 years, and from there you can work  
25 out whether or not you need beds, chairs or whatever the  
26 service is, and you can calculate into the algorithm all of  
27 the post-codes that would feed into that particular  
28 hospital. So it's quite a sophisticated planning tool and  
29 very helpful in really being able to make decisions and  
30 recommendations in the clinical services plan.

31

32 Q. Will there be occasions where that planning tool  
33 identifies a series of services or needs within a community  
34 which are simply not all able to be accommodated within  
35 a budgetary envelope which has been made available for the  
36 redevelopment or rebuild of the hospital?

37 A. That can happen.

38

39 Q. How are decisions made in those instances as to what  
40 should be prioritised? Does the software give you  
41 a ranking of what there should be or are there some hard  
42 decisions to be made there?

43 A. No, it does not. There are hard decisions to be made  
44 there. I guess what we would always try and do in a  
45 building where that happens - because money is always  
46 tight - is to do a value management process where a number  
47 of stakeholders come together, and I've been involved in

1 quite a few of these where you actually prioritise what it  
2 is that is important that you're going to do and what you  
3 could possibly do a different way.  
4

5 Q. When you say "value", is that value in terms of what  
6 you might perceive to be the patient outcomes --

7 A. Yes.

8  
9 Q. -- that can be derived through a particular service  
10 over another?

11 A. Yes.

12  
13 Q. How are they measured or estimated?

14 A. So in the value management process, we would always  
15 look to see where we could cut down on the actual physical  
16 infrastructure to continue to provide the number of beds or  
17 the number of chairs. That's how we - that's generally how  
18 we do it. We might say, "We'll have three less meeting  
19 rooms, so that we can have three more beds over in that  
20 ward, which we can't have in the current funding envelope."  
21

22 So, for example, when we did one build, we moved  
23 BreastScreen to the city, here in Wagga, because we put it  
24 in - near a shopping centre, because that really suited the  
25 women but it also meant that we didn't have to have the  
26 infrastructure costs which helped us to contain the budget.  
27 So it was a win for the women in terms of they had their  
28 BreastScreen downtown, you can see it, it's not far from  
29 here, and it substituted the women, they were really happy,  
30 but it also suited the infrastructure project. So we try  
31 to make decisions that maximise the benefit for the  
32 clinical service plan delivery.  
33

34 Q. Can I ask you one last question. You've told us a lot  
35 about what's working really well in the LHD. We've also  
36 talked about a couple of the wicked problems, but are there  
37 things that we haven't mentioned that you think are not  
38 working particularly well in terms of the delivery of  
39 health care within the LHD that could work better if  
40 systemic change was made at any level and, if so, what are  
41 they and what's the change that - picking up your wand  
42 again - you would invite us to recommend?

43 A. Oh gosh. It would probably be in the mental health  
44 space. The needs for mental health in rural communities  
45 are really quite high, and in many circumstances, a lot of  
46 the mental health patients are not known to our service,  
47 because they are largely being treated in primary care, and

1 I'm not certain that we always intersect well with people  
2 who have got that low acuity early onset anxiety,  
3 depression, and I think there's sometimes a gap, and we are  
4 obviously at the pointy end, and we only have quite a short  
5 treatment time with people, but I don't think that there's  
6 anywhere that's really doing great therapeutics with people  
7 in the early stages of mental illness, and I think that  
8 continues to be a problem that we all are grappling with.  
9 And there are so many different service providers in mental  
10 health, and so many different sources of funding - how can  
11 we actually bring that together so that people are not so  
12 confused about where they go and how they are going to be  
13 able to stay there or get moved on to another service? So  
14 I think that there's more to do.

15  
16 Q. Do you have any thoughts about how that might better  
17 be achieved within your LHD, at least, if not more widely?  
18 A. There is a new Head to Health process coming our way  
19 and is meant to address some of these issues, so let's see  
20 if we can make that work. But that's only in two  
21 communities, so in terms of health equity, what does that  
22 look like from a broader sense?

23  
24 MR MUSTON: Thank you.

25  
26 I've got no further questions for this witness,  
27 Commissioner.

28  
29 THE COMMISSIONER: Thank you. Mr Chiu?

30  
31 MR CHIU: I have no questions, Commissioner.

32  
33 THE COMMISSIONER: Ms Ludford, thank you very much for  
34 your time. We're very grateful.

35  
36 THE WITNESS: Thank you, Commissioner.

37  
38 THE COMMISSIONER: You are excused.

39  
40 <THE WITNESS WITHDREW

41  
42 THE COMMISSIONER: That completes these hearings.

43  
44 MR MUSTON: It does. I am trying to quickly work out what  
45 date in April we're adjourning to. Someone will tell me.

46  
47 THE COMMISSIONER: It is some time in April.

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MR MUSTON: 15th, thank you.

THE COMMISSIONER: In Sydney?

MR MUSTON: In Sydney.

THE COMMISSIONER: Excellent, all right. We'll adjourn until 15 April in Sydney.

Thank you, all of you.

MR MUSTON: Thank you.

**AT 2.46PM THE COMMISSION WAS ADJOURNED TO MONDAY, 15 APRIL 2024 AT 10AM IN SYDNEY**



<p><b>\$</b></p> <hr/> <p><b>\$60</b> [1] - 1684:46</p> <hr/> <p><b>0</b></p> <hr/> <p><b>015</b> [1] - 1650:24</p> <hr/> <p><b>1</b></p> <hr/> <p><b>1</b> [2] - 1658:41, 1730:26</p> <p><b>1,000</b> [1] - 1662:14</p> <p><b>1.45</b> [3] - 1720:18, 1720:23, 1720:29</p> <p><b>1.8</b> [1] - 1659:28</p> <p><b>10</b> [11] - 1656:14, 1656:18, 1674:4, 1681:17, 1681:18, 1681:33, 1686:42, 1688:27, 1718:41, 1720:41, 1742:24</p> <p><b>10.00am</b> [1] - 1650:22</p> <p><b>100</b> [1] - 1695:4</p> <p><b>101</b> [1] - 1722:33</p> <p><b>109</b> [2] - 1733:8, 1733:13</p> <p><b>10AM</b> [1] - 1745:16</p> <p><b>10am</b> [1] - 1651:1</p> <p><b>11</b> [1] - 1722:13</p> <p><b>11.20</b> [1] - 1686:24</p> <p><b>11.40</b> [1] - 1686:25</p> <p><b>11.40am</b> [1] - 1686:31</p> <p><b>117</b> [1] - 1736:7</p> <p><b>118</b> [1] - 1739:6</p> <p><b>119</b> [1] - 1740:10</p> <p><b>12</b> [8] - 1653:42, 1654:25, 1678:24, 1678:29, 1686:45, 1687:30, 1722:13, 1727:41</p> <p><b>124</b> [1] - 1724:44</p> <p><b>128</b> [1] - 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