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)

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

Also present:

Mr Hilbert Chiu with Mr Christopher Chiam for NSW Health

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

THE COMMISSIONER: Good morning.

MR GLOVER: We will continue with Professor Bruce.

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

<EXAMINATION BY MR GLOVER CONTINUING:

MR GLOVER: Q. Professor Bruce, yesterday afternoon, before we adjourned, I asked you some questions relating to the treatment of public patients in private facilities as part of reducing the backlog, if I can put it that way. Do you remember that evidence?
A. That's correct, yes.

Q. I asked you whether there was a process to determine the patients which would form part of that approach, and you described how the clinicians would prioritise cases. Do you remember that?
A. That's correct, yes.

Q. Is there anyone else involved in determining the cases which would go to be treated in those private facilities under that arrangement?
A. We do have a district surgical services lead that oversees our sites where we do surgery and she would have a look at the wait list, clinical priority of patients. We look at the time available in particular lists, the length of procedures, to try and maximise the utilisation of our theatre capacity.

Q. And what about the determination of which cases go to which of the facilities that the LHD has an arrangement with?
A. In the end, for us, different facilities offer different services, and part of it is also if a surgeon already has a list at a particular facility, we can actually use - we use unutilised private capacity. So let's say a surgeon has a private list at a particular facility and there's capacity on that list, we can actually use that time and put some public patients on that.

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

would have the patient in the public facility, if there was capacity?
A. In most cases, yes. There are some cases, for instance, if surgeons are unwell, that we can actually move patients between different surgeons.

Q. Are there any overarching policies which apply to these decisions?
A. There is a New South Wales wait list health policy that manages it, but for us, it really is just the patient is at the centre of what we do, and obviously we try to be as financially responsible as we can be.

Q. When public patients are treated in private facilities under these arrangements, are there any increased costs to the state system in doing so?
A. At times, yes. So as part of the wait list arrangement last year, there was an agreed rate, but I would probably need to check with our team if there's any commercial in confidence information about what the particular rates are. But it can be more expensive at times, yes.

Q. When you refer to the "arrangement last year", that was a push to reduce wait lists across the state; is that what you're referring to?
A. That's correct. Patients that were delayed as part of the COVID pandemic, so we did receive additional funding to make sure that those patients got treated as soon as was practicably possible.

Q. What about going forward? Do you see or perceive the need for this type of approach to continue?
A. From our point of view, we would try and do as much as we can in-house, but as discussed previously, there are challenges with specialised nursing workforce, so perioperative nursing staff, medical staff at times, so there may still be a need for some utilisation of private capacity while we build our own.

Q. In that context, the utilisation of the private capacity is because those are procedures that may not be able to be performed within the facilities in the district; is that what you're referring to?
A. Some of them cannot, that is correct, yes.

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

A. I do, yes.

Q. If I can take you to paragraph 7?
A. Yes.

Q. Paragraph 7 to 13, you address the topic of premium labour?
A. That's correct.

Q. Do you see that?
A. Yeah.

Q. Premium labour is locums and agency nursing staff; is that right?
A. That's correct.

Q. Does it include any other categories?
A. We do occasionally use premium labour in allied health, but probably the most common would be medical and nursing.

Q. Has there been a trend of increased reliance, a need to rely on premium labour in the district?
A. Probably one of the areas where there have been changes is in the district hospitals where previously, the utilisation of locum or premium locum medical staff would have been very rare. Unfortunately, it is something that is becoming more common and we are in positions where we have to utilise agency staff in our busy district hospitals, especially where you've got high volume emergency departments. That's probably the areas where we've seen increased utilisation.

Last year, as part of the surgical recovery program, we did need increased specialist anaesthetists to help us perform the additional surgery, and in terms of the emergency department, the specialist locums were probably reasonably stable because we have a certain number of FTE and there's some fluctuation in terms of the so-called mid-grade medical staff.

Q. In paragraph 12 of your outline you identify the ideal scenario where premium labour might need to be used, and that is to cover leave --
A. That's correct.

Q. -- permanent staff? Has there been a shift within the

district to use premium labour more widely than what you strike as the ideal scenario?
A. Well, it's a sign of necessity. We would always try and, you know, use employed staff, our own team, not just because of the financial benefit but there are significant clinical care benefits in staff knowing their environment, understanding the clinical context, people working in a team where the team members are familiar with one another as well.

Q. That's why the ideal scenario is the ideal scenario; correct?
A. That's correct, yes.

Q. One way it's been put to the Commission is that premium labour, in your ideal scenario, would be a support to the system?
A. That's correct.

Q. But there have been trends in recent times where it is becoming an integral part of the system; would you agree with that?
A. Yes, unfortunately so.

Q. In paragraph 12 you tell us that some of the emergency departments within the district rely on premium labour to cover the emergency departments?
A. That's correct, yes.

Q. By that, do you mean that those emergency departments are staffed entirely by premium labour?
A. There would be, you know, from memory, I think probably one of our district hospitals that relies almost solely on premium labour. There would be other ones where we need premium labour as part of the rest of the team. But you would say that it's an integral part of the workforce.

Having said that, there is a benefit of having locums that return regularly, so at least, even though they, you know, incur premium cost, at least they're familiar with the facility and familiar with the staff.

Q. Apart from familiarity, are there any other benefits to the use of locum or agency staff that you see?
A. Well, there are benefits that we get exposed to clinicians with, you know, a broad range of experience and,

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

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

Q. Aside from cost, which I will return to in a moment, are there any particular downsides to the increased use of premium labour within the district?
A. Well, there's obviously all the on costs - travel, accommodation. There's a risk of people cancelling. Every time we utilise a new locum, there is a component of risk because we've not met them before, you know, even though they are good and capable clinicians, they may not always be a fit for the particular area where they're going to work, so there definitely are some downsides to it. We obviously have to provide accommodation to them as well and that can be challenging, if you utilise large numbers of locums.

Q. Are you familiar with the costs incurred by the district in engaging premium labour?
A. Yeah, I unfortunately don't have the exact number for that, for the whole district, unfortunately.

Q. Are you aware whether the number has been increasing over recent times?
A. Well, from memory at Wagga Base the numbers have increased.

Q. What about in other parts of the district?
A. There would be some of the smaller facilities where the numbers would have increased but I don't have exact numbers.

Q. In paragraph 13 of the outline you tell us that the district is strategic in how locums are deployed?
A. That's correct.

Q. What do you mean by "strategic"?
A. So for us, there's a threshold where we believe ideally you should have a doctor on site or available to attend if required, and those are the areas where we engage

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

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

Q. In that answer you referred to a threshold. What is the threshold that you are referring to?
A. For us, if there's less than 10 presentations per day, we wouldn't really put a doctor in a particular site. That can go up because we also look at the acuity of presentations, so you could have an emergency department where there's 15 presentations but if 10 of those are low acuity presentations, like category 4 and 5, they can easily be managed through virtual care. So we look at numbers and also the acuity of the presentations.

Q. Is part of the analysis in that strategic deployment of locums a comparison between what it would cost to staff it, with a locum, versus the cost of delivering the virtual care model?
A. We do look at cost but our first priority always is, you know, patient and staff safety. So we do consider finances but, in the end, you have a limited resource and what we need to work out is where is the best place to deploy that particular resource.

Q. Just while we're on the virtual care model, has there been any analysis done on the effectiveness of that model in delivering the care into those EDs where it's deployed?
A. Well, I think what we need to look at is how do you define effectiveness? For me, firstly, you know, is the care safe? We have an incident monitoring system and to the best of my knowledge, there's no increased incidents in patients being cared for through virtual care.

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

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

Q. And if I can just come back to the costs, not wishing to distract from the importance of the issues that you've raised, but have there been any analyses done on the cost to deliver the virtual care model within the district?
A. Well, we know what the costings of - because we use a third party provider, so then there definitely would be cost of exactly how much we're spending on it. I think that the benefit for us is that the rate of remuneration is competitive to what a normal medical officer would earn, but the benefit is they cover a large number of hospitals. So having virtual care technology you can have one doctor that covers five hospitals, where if you had to put a doctor in each of those hospitals, the volume probably wouldn't justify it and the cost would be significant.

THE COMMISSIONER: Q. Professor, who is doing the formal evaluation of your remote medical consultation service? Is that internal or some external group or body doing it?
A. I would have to take that on notice, sorry. I don't know.

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

THE COMMISSIONER: The chief executive might, later.

MR GLOVER: Q. Do you have your outline there, Professor?
A. Yes.

Q. In paragraphs 14 and following you refer to some initiatives. Can I just take you to paragraph 14?
A. Yeah.

Q. There you refer to opportunities to address the demand on services?
A. Yeah.

Q. So yesterday, I raised with you whether the approach was, in my words, a two-pronged approach, one to reduce demand, one to increase supply as part of the approach to workforce challenges. Do you remember that?
A. Yes, that's correct.

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

opportunities that you see to influence the demand side of that equation?
A. That is correct, yes.

Q. If we can start with 14(a), there you refer to investing in primary health care to improve the general health of the district community. Do you see that?
A. That's correct.

Q. What do you have in mind as an opportunity for the district to invest in primary health care?
A. I think the primary health care, the way that I look at it, it really is preventative health care, and as we spoke yesterday, that there is a certain threshold for a general practice to be viable, but if we can combine that with hospital work, that can actually create an attractive proposition for a medical officer. That would be one.

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

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

THE COMMISSIONER: Q. It is not the purpose for it, obviously?
A. That is correct. And I think we see that, if we look at the performance of the Wagga Base emergency department, for category 1 and 2, the true emergencies, they perform extremely well, but then, as we move down through the triage category, the effectiveness of the service is actually not good, and what we did was to look at the models that are available overseas.

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

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

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

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

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

Q. Can I just break up some of the concepts in that answer?
A. Sure.

Q. The first you mentioned is that there was an opportunity to support general practice with hospital work. By that, do you mean providing opportunities for general practitioners to act as GP VMOs?
A. That's correct, yes.

Q. The second is that you referred to the support through multidisciplinary teams?
A. Yes.

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

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

Q. So these are services that you perceive as being delivered in the community or in the facility, or both?
A. Well, it would be a combination. I think there are benefits of having a health hub in the community, which is the facility, especially because we've got access to very good telehealth facilities which may be better than what patients have access to at home, and I think it is very nice to have that health hub in a particular community.

Q. Are public outpatient clinics part of this process?
A. Most definitely. For us, probably that's one of the major areas of development, you know, especially at Wagga Base, and there has been, you know, some increase in the clinics that we provide. But obviously for us, it will take a significant period of time to develop, you know, a complete suite of services.

Q. What about for those communities in the district that are removed from Wagga Base? How are those facilities to be - how are those services to be delivered to those communities?
A. Well, there's definitely a role for telehealth, because it does increase the reach, you know, even though it is ideal for practitioners to outreach in person, travel time is down time, and if a doctor spends four hours in the car driving, they're not seeing patients in those four hours, so I think we really need to look at building capacity locally and having general practitioners with advanced skills so you can - what we call, co-consultation, where the patient will be with their GP in the community and the specialist will use technology to dial in and they'll essentially have a multidisciplinary discussion.

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

care is access to specialist care where there may not be a specialist on the ground; correct?
A. That's correct.

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

Q. Is there a risk that an increased use of virtual care might further centralise specialist services in metro or larger centres like Wagga Wagga?
A. Well, clearly it can be, but that's why our role is to have a critical mass of staff locally and to build on our relationships with metro hospitals, where staff actually come down and visit. But once again, there are certain benefits through virtual care that we would never be able to meet. The classic example is the Teleburns service that we run out of the Wagga Base rapid access clinic, where patients are followed up in consultation with the specialist burns unit at Concord. It would be highly unlikely that we would ever have a specialised burns unit in Wagga, but it means that a patient from the Murrumbidgee will have the same access to sub-specialty care as someone in Sydney, which is great.

Q. What you are describing there is maintaining access for those communities whilst also fostering and maintaining a local capacity?
A. That's correct. And a big part of virtual care is actually building local capacity when they interact with our clinicians, we become more comfortable, and a lot of it is really about making sure that we extend the skills of the clinicians that we have.

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

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

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

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

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

Q. So the headline statistic may not reveal the true story, but do I take it from that you're confident that since the implementation of the rapid access clinic, there's more patients being treated in that context than would otherwise - that would previously have remained in the ED?
A. Well, they would have just stayed in the emergency department. Probably the easiest win we had were patients is that presented for non-elective orthopaedic surgery. Historically, they would have presented to the emergency department and then be admitted through that, which is not, you know, the role of the emergency department, and then in the last six months of last year, we had about 700 patients that went through our rapid access clinic service.

Q. These are patients who may have broken a limb and require surgery?
A. That's correct. So let's say you break your arm, you present to ED, yes, you need an operation, you need to come back tomorrow or Sunday. Historically you would be told to re-present to the emergency department where you would require the resources of ED, the nursing staff, sometimes medical staff, those patients are now just - they present to the rapid access clinic and they really walk around the corner to the operating theatre.

Q. Another of the opportunities to address the demand side of the equation that you identify is the expansion of scope of practice of other health care providers?
A. Most definitely. I think unfortunately in Australia

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

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

Q. The concept of expansion of scope and permitting those practitioners to practise at the top of their scope --
A. That's correct.

Q. -- is there scope to - "scope" isn't - again, I'll rephrase it. Are there opportunities to perhaps permit those practitioners not only to expand their scope but better practise at the top of their level?
A. Well, clearly training is an important component. The other bit is support and networking, where we can provide, you know, either virtual support or in-person support in the town to support other practitioners.

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

Q. Is there anything the system could do to harness those opportunities better?
A. I think having model scopes always helps us, from a credentialling point of view, if there's a statewide, you know, model scope for particular clinicians, which there already is for some of the nurse practitioner roles. Not necessarily from a state system, but from a federal system, there are certain funding implications, depending on who

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

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

Q. Do you perceive there to be any resistance within the system to expansion of scope of practice by some of the practitioners that you've referred to in your evidence?
A. There may be. Clearly there's always a concern of different craft groups encroaching on one another's, you know, patch, for lack of a better word, but in the end, that is just change management that we need to go through.

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

Q. Is there something that the system itself could do to perhaps facilitate that discussion to overcome some of those barriers?
A. Yeah, I think, you know, early clinician engagement with different professional bodies is important right at the start, and I think for us it's about how we work effectively together. But it would have to be part of it that, you know, nurse anaesthetists would not work completely independently from, you know, physician anaesthetists. There is an interaction and a synergy, similar for, you know, nurse endoscopists, so I don't see that as an insurmountable problem.

Q. However it may ultimately be structured, do I take it that you see those practitioners operating to the top of the scope of their practice --
A. That's correct.

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.

Q. What do you see as the state health system's role in the management of those chronic conditions in the community?
A. Well, we have a very important part or role because those are the needs of the community that we serve. We work for that population of the Murrumbidgee, and we need to look after them. So we have a very important role to do that, and if we look at strategies that work effectively, so the collaborative commissioning would be one example, MRGTP, those strategies are areas where the federal and state funding is actually pooled, and while we have the separate funding models, it will be very, very difficult to have integrated services.

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

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

Q. Is the concept you're referring to there the need to deliver the care where it's needed when it's needed, irrespective of who funds it?
A. That's correct. Well, in the end, Australia funds it. Whether or not it comes from either the state or the federal government it doesn't matter; the Australian taxpayer is funding it. I think one of the benefits that New Zealand does have is that primary care is in the remit of the district, it's not completely separate, and as soon as different structures are separate, with their own KPIs, their own performance, it becomes challenging.

Q. In paragraph 17 and following of the outline you refer to the opportunities to increase the supply of the workforce?
A. Yeah.

Q. And in paragraph 18 you identify the need to attract medical students by expanding the training beyond large hospitals?
A. Yes.

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

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

A. Yes, yeah.

Q. What is the issue that you are referring to there?
A. Historically, medical students are trained in large tertiary facilities, so the only care that you ever see are the patients that are in hospital. You don't see that vast group of patients that are actually never admitted. So we have improved that by having some rotations into general practice, but it's still a fraction of training.

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

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

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

Q. That's the benefit of the rural clinical schools?
A. That is correct, but also the model and the program that you deliver, because Wagga Base is really a tertiary referral hospital and if the students only train in Wagga Base, they would be missing out.

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

A. That's correct, yes.

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

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

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

Q. So do you perceive then there needs to be more flexibility in the model to cater for those need?
A. Most definitely. You know, we - there's benefits to the centralised system but we need to be sensible in terms of accommodating students who want to be here.

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

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

to rotate to metropolitan areas to undertake training in fields where that training is not available?
A. That's correct.

Q. How does that differ from the current model?
A. Well, in the current model, the vast number of training positions are in metro hospitals, and the trainees will come and rotate to us for three to six months, but in the end, they spend the bulk of their training in the metro hospital.

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

Q. In terms of the training positions for specialist training, does that require engagement with the respective colleges to put into place the opportunity that you identify in paragraph 21(a)?
A. Most definitely. I think we need to appreciate that the positions belong to NSW Health, but the accreditation of the position belongs to the college, and I think where there are challenges is where colleges with very good intentions stray into industrial and other employment arrangements as part of accreditation.

Q. What do you mean by that?
A. They do sometimes, you know, have broader requirements of hospitals that i not necessarily directly related to training. A classic example of colleges that recommend specific amounts of what they call clinical support and non-clinical time as particular fractions, and, you know, I had the accreditation by the college of anaesthetists

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

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

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

Q. -- do you perceive that the colleges are willing to bring flexibility to their models to facilitate more training of specialists in rural and regional locations?
A. I think some colleges are more flexible than others, but most definitely. I think a very good example is the college of psychiatry. They are very, very supportive, and the college of anaesthetists are supportive and, you know, when we explained our scenario, they were happy to compromise, so I definitely believe that the colleges would be happy to work with the different states to facilitate training.

Q. And I take it from that answer that you see there's scope for more training in other specialist disciplines in rural and regional locations?
A. Most definitely. I think where we need to be a little bit more flexible is supervision. It's quite fascinating that we see virtual care as suitable for patient care but it's not always seen as suitable for supervision. So I think we need to re-look at how we deliver care, how we deliver training. You know, we even use virtual assessment in Murrumbidgee where I can virtually look at someone performing BLS. It really is just, you know, we need to think more broadly.

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

these types of requirements?
A. We have been in discussion with the college of physicians in regard to a palliative care position that we've had.

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

Q. Do you think there would be benefit in perhaps some established protocols between NSW Health as a broader system and each of the colleges to enable these sorts of discussions to take place as and when needed?
A. Most definitely. Most definitely. I think if there's a shared understanding it just speeds things up a lot.

Q. In paragraph 21(b) you identify the rural areas would benefit from more generalist multiskilled specialists?
A. That's correct, yes.

Q. Can you just expand on that concept, please?
A. So I think the first thing to remember is that apart from the US, Australia has the largest number of sub-specialties in the world, which is quite fascinating. We have a very large country, sparse population, and we are very, very sub-specialised.

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

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

Q. Aside from that change in status of multiskilled specialists, how can the system address the need on the one hand, particularly in rural and regional areas, for multiskilled specialists against the trend of increased sub-specialisation?
A. I think we need to look at the way services are remunerated. It is biased towards procedural specialties.

Q. What do you mean by that?
A. Well, it just means that a doctor can earn more money doing procedures than they can to see patients, and I think, you know, that is a challenge.

Q. Is that a disincentive, in your view, to the type of multiskilled specialists that you identified?
A. Most definitely, because there's security in being a master of a very small field, while if you have to manage a broader range of conditions, you have to be a little bit more vulnerable because you may be presented with something that you're not that familiar with, and clearly, generalists, because they can do more, there's a potential that they have more on-call commitments.

Q. In paragraph 25 and 26 you refer to some funding challenges.
A. Yes.

Q. In paragraph 25 you highlight that the district doesn't have control over demand for its services --
A. That's correct.

Q. -- where surgery is one?
A. Yes.

Q. And you say that can lead to an unfavourable budget. How does that arise?
A. Yes, so in my role as the general manager of Wagga

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

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

Q. With your general manager of the hospital hat on, how does the budget allocation process work?
A. Well, so there's obviously the state sets up a purchasing agreement with a local health district and then, as part of that, the district's finance team distributes the budget to different facilities, and Wagga Base will get a block of funding and then we then allocate it to different services but --

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

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

Q. But the budget envelope may not cover it; is that right?
A. That's correct, yes.

Q. And then, two, does it act as a disincentive to complete activity in that budget year?
A. We're focused on patients. Our role is to look after them. So, you know, we do the work, and what really try to do, as we do in rural areas, we try to be as efficient as possible to limit the financial impact of the additional

activity.

Q. In an earlier answer you said that there is an ability to obtain budget supplementation --
A. That's correct.

Q. -- but it happens after the event?
A. That's correct.

Q. What challenge does that pose to you as general manager of the hospital?
A. Well, it means that on a month-to-month basis, you know, I may have an unfavourable budget, which would then also reflect on the financial position of the health district.

Q. That unfavourable budget, would that reflect unfavourably in your KPIs as a facility?
A. Yes, because financial sustainability is an important, you know, KPI for us.

Q. In terms of that KPI, however, there's little that you could do about it, because you're meeting the demand for services; is that fair?
A. That is correct. But I also have a responsibility to be as efficient as I possibly can, and that's why we're constantly looking at improving our services and the way we deliver, and strategies like, for instance, day surgery joint replacements, reduces the cost quite significantly for us to provide that particular service, while we still get the same funding. So that's - as I mentioned previously, we need to think differently about the way we deliver care to make it more efficient.

THE COMMISSIONER: Q. I assume for that, though, you've got to be careful about picking patients that are right for a day surgery for a hip replacement, because that won't be everyone?
A. No, that is correct, and that's why we're actually looking at expanding that model through our "Hospital in the Home" service, where the patient is not necessarily suitable as a day case but we could get them home a day earlier with support services that we've got in place.

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

A. Oh, most definitely.

Q. How that's going to happen?
A. Yeah. It's done by the specialist when they actually are consulted initially, and there's actually a process that they need to go through. It's not a - you turn up and they say, "By the way, you'll be going home this afternoon." There's quite an extensive process of education. They meet the allied health staff before, they will meet the "Hospital in the Home" staff. So there's a significant investment for us, but the return is infinitely more than the time we invest.

Q. So assuming everything goes well with a particular replacement procedure, the patient either knows it's going to be: I'm going to go home that night or it's going to be --
A. Yes.

Q. -- 36 hours, 72 hours, is the estimate?
A. Yes.

Q. And they know that in advance, obviously?
A. Yes, yes, most definitely. There's definitely a plan, and we call it our criteria-led discharge, where there's actually a pathway, and there may be times when we have to vary from the pathway --

Q. Things can go wrong?
A. That's discussed with the patient, but most definitely, yes.

Q. "Wrong" might be the wrong word.
A. Well, unplanned, or it may be that someone's going so well that they can actually go home sooner, and most patients actually are keen to get back --

Q. Then there is a clinical decision made, "This patient has actually exceeded expectations for recovery" --
A. Yes.

Q. -- "we think they can go."
A. You know, it's always focused on the quality of care. We never have finances as the main priority when we deliver care.

Q. Well, that would be really dangerous.

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

THE COMMISSIONER: Sure.

MR GLOVER: Q. In terms of the way that the budget is allocated to the Wagga Base Hospital and the challenges that you've identified in your evidence today, what could be done differently to support you as a general manager of a facility like the Wagga Wagga Base Hospital?
A. We're extremely well supported by the district. I think probably one of the areas that I've seen change over the years is the closer synergy between clinical staff and the finance and performance team. They are really part of the team that deliver care.

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

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

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

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

Q. What could be done differently to take that pressure away, at a system level?
A. I think there should be some way for the system to adapt. Even though we have projected activity, there should be a way for us to adjust funding if activity, you

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

Q. In-year, do you mean?
A. No, I think it's adjusted every two years. It's not as quick, but, you know, we'd predicted that the activity would go down to baseline, but it's not, and there needs to be a way, you know, for us to be able to manage that.

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

Q. What's challenging about funding new models of care within an activity based funding structure?
A. So when we move services to a different model, it's not that one day we switch off one service and start the new one. So there will be a period of time where you have to run both, and that's the venture capital that we need.

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

Q. So is the challenge --

THE COMMISSIONER: Q. It may not be clear for a long time. I mean, evaluation can't be done --
A. You know, it's very, very difficult because you need matching, because the most complex patients go to the acute geriatric service, which is the best for them. But if you then go and look at a crude measure, like length of stay, well, the length of stay is long, but we don't know how much longer they would have stayed if they were in a different ward, and I think part of the problem with our data is that we measure the things that are easy to measure, that we can count, and it's those other, more nuanced outcomes for patients that is more difficult to measure, and that's really what we need.

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?

A. Yeah.

Q. And then certainty of funding going forwards?
A. That's correct.

Q. And so what could be done differently in that scenario?
A. Well, I still believe there should be a proportion of funding allocated to different models of care to be able to do it, which is in addition to the ABF funding for the activity.

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

Q. What about the length of the commitment of funding of that kind?
A. Yes, I think the commitment of the funding should be matched to the time frame that we believe it would take to demonstrate the outcomes and that would vary between different initiatives.

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

Q. Is that something that's within your remit? I take it by that answer it might be?
A. Oh, yes, no, it's - so as the district director of medical services, overall I'm responsible for the medical services in the district, and I can assure you that discharge summaries is as much of a priority for us as it is for other clinical staff.

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

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

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

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

THE COMMISSIONER: Q. Who is on the working party in each of --
A. So it's multidisciplinary. So it's medical, nursing, allied health as well, and really it's just a process for us to improve it, because it works well in the non base hospital sites where the doctors pretty much do a discharge summary to themselves. It is a little bit more tricky when you're the junior doctor in the medical team where there are 30 patients, we discharge 10 today, plus you still have to do all your other tasks.

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

Q. Do you accept that there is a portion of discharge summaries that are not delivered, I think you said, within the 48 hours?
A. There would be a number of discharge summaries that are not delivered. Having said that, though, when we transfer patients to peripheral hospitals, there's actually a clinical handover between clinicians, so one of the team at Wagga Base will contact the accepting doctor, and the

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

Q. Do I take it you accept there is an issue with the timeliness --
A. Yes.

Q. -- of discharge summaries within the district?
A. Yes.

Q. The second issue we have heard is the content of the discharge summary?
A. Yes.

Q. You mentioned a concern about some of them being overly comprehensive?
A. That's correct.

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

Q. I take it you would agree with the proposition that the discharge summary is important?
A. Most definitely.

Q. In the ongoing care of the patient?
A. Yes.

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

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

Q. Is the district doing any auditing of discharge summaries, whether as to timeliness or content?
A. So most of the audit is actually done in terms of timeliness. Clearly, if we get feedback about a discharge summary that is not accurate or, you know, too comprehensive, we can feed back, so we essentially get a weekly report of the number of discharge summaries that are outstanding. And from memory, the medical records department would occasionally do some audits to actually look if it meets the minimum requirements, but the minimum requirements are really the minimum requirements; it's not necessarily a good quality discharge summary but it's got the minimum information that needs to be on it.

Q. So the measurement of timeliness is measuring just one of the issues that has been raised with you about discharge summaries; correct?
A. Yeah, that's correct, yes.

Q. What work is being done to measure whether, to pick up your language, there's an improvement in the quality of discharge summaries and also whether they are patient friendly?
A. Well, so a patient discharge summary would be different to one that's sent to a clinician, so that's an area --

Q. Just to answer my question, is there work being done to measure whether there's an improvement of the quality of discharge summaries as part of the working party that you've stood up, or is it only measuring timeliness?
A. Well, the timeliness is measuring at all times, but part of the working party is actually to improve the quality with education and training.

Q. I understand that's part of the working party, but what measurement is being done to determine whether it's achieving that outcome?
A. I would need to check with the other members of the working party if we've got a formal evaluation of the

quality of the discharge summary.

Q. That would be important, to assess the effectiveness of the working party's work, would it not?
A. Well, I would probably focus on feedback from the GPs, because, in the end, it's probably more important that the GPs feed back that they're happy with the quality of the discharge summary than us assessing, because they're the consumers of the discharge summaries. So if I was doing an evaluation, I would probably do a survey with --

THE COMMISSIONER: Q. Is there GP representation on the working party?
A. I would need to check the exact membership, but we obviously have GPs that work for us and they can be part of that.

MR GLOVER: Q. Finally, can I ask you about VMO payments --
A. Yes.

Q. -- or payment claims. Is that something that falls within your remit?
A. Yes.

Q. We've heard some evidence earlier in the week about concerns from GP VMOs around issues regarding payments being rejected or delayed. Are you aware of concerns of that kind being raised within the district?
A. Yes. We've had, you know, feedback from some clinicians where they feel that their claims are delayed, yes.

Q. And has there been work done to address those concerns when they have been raised --
A. Yes, so --

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

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

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

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

Q. One of the concerns about which we've heard evidence in that scenario is the effectiveness of the communication between the relevant area of the district responsible for assessing and paying claims and the clinician. Is that an issue that has come to your attention?
A. I think that there's two different services that manage this. So there's clearly the base hospitals, where there is very strong process, and that's really led by the clinician. And we contact them in a way that they would like to be contacted, either through their practice manager or to themselves, and it's really not a rejection; there's an inquiry to say "The following line" - it normally is, "We need more information from the medical record to justify payment of the claim."

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

Q. These are individual instances. Do I take it from that answer you're not aware of any wider systemic concerns being raised as to the quality of communication between GP VMOs and the areas in the district responsible for assessing and payment of claims as to the adequacy of communication?
A. Well, there's a process where the facility would reach out to the doctor. I think we need to be careful about looking at individual circumstances and extrapolating that to a district-wide. So it could be that particular individuals have more challenges with claims management, but the vast majority of doctors find it a reasonable seamless process.

MR GLOVER: Thank you, Professor Bruce. That's all the questions I have.

MR CHIU: I have no questions, Commissioner.

THE COMMISSIONER: Professor, thank you very much for your time. We're very grateful for your evidence and you are excused, thanks.

<THE WITNESS WITHDREW

THE COMMISSIONER: Shall we have a short break before --

MR MUSTON: It is probably convenient, otherwise the next witness will spend seven minutes in the box and then be out again.

THE COMMISSIONER: How long do you think we should take? Are you comfortable about when we are going to finish?

MR MUSTON: Yes.

THE COMMISSIONER: It's 11.20. We will come back at 11.40. We will adjourn until then.

SHORT ADJOURNMENT

MR MUSTON: I call Jill Ludford.

<JILL LUDFORD, sworn: **[11.40am]**

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you give us your full name for the record, please?
A. Jill Ludford, chief executive of the Murrumbidgee Local Health District.

Q. You have been in that role as I understand since August 2014?
A. Correct, coming up for 10 years.

Q. You've prepared a statement for the benefit of the Commission dated 12 March 2024?
A. Yes.

Q. Do you have a copy of that statement you?
A. I do.

Q. Is the content of that statement, to the best of your knowledge, true and correct?
A. It is.

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

THE COMMISSIONER: Thank you.

MR MUSTON: Q. Can I start by asking you a little bit about collaboration. A feature of the evidence we have heard over the past week has been the strength of collaboration within your district between the LHD and other associated entities involved in the delivery of health care to the people of your region. Can I ask you, what is it about collaboration that you think is important in the delivery of health care, from the perspective of the chief executive officer of an LHD?
A. So I think I had the benefit in my career of working in the operations of a local health district, which is understanding the function and the bread and butter of running hospitals. And so when I commenced in the role, I could see the benefits and the potential if we reached out and collaborated outside of perhaps our own organisation, but also the importance of reaching into the clinicians and it was very much a deliberate strategy in my, I guess, first 12 months, to first of all cement the relationships within the organisation, because I think the clinicians, at the end of the day, make the decisions about patients, but that also means they make the decisions about the resources and the usage, so there was some work that was undertaken around improving the clinician engagement in the first instance.

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

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

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

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

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

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

Q. What was the state of that engagement like when you first arrived in the job? I know you've been here for a while.
A. I can actually remember, when I first started and it was said to me, "Well, there's no point, actually, asking the primary health network for help because they don't want to know about us", and that was really the state of where we were.

Q. Why do you think that was?

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

Q. What did you do to try and turn that around?
A. So I guess I'm not really interested in the personalities; what I'm interested in is the system approach. So again, I can remember back, I asked if I could meet with their general practitioners, because general practitioners were always viewed as contractors in the district when I started. However, given that they are a critical part - I've got 31 hospitals and 29 of them are made up of general practitioners - if we didn't have a relationship with them or the body that was overseeing them, then there was something that wasn't quite right.

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

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

Q. That's the then chief executive of the PHN?
A. The primary health network, sorry, the Murrumbidgee Primary Health Network.

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

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

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

Q. In terms of the way you worked together, what was it about your engagement that you think was - or the way in which you engaged with the PHN that you think was effective?
A. Having a structure and making sure that we were very deliberate on making our actions focused on data and outcomes for patients, and then having, I guess, a system to report that as well, so that we were holding ourselves accountable.

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

Q. What are they? Feel free to give us a long list.
A. Right. Okay. Look, I think if I may just say, though, that it's very important that you have the structures in place before you embark on something large.

Q. So pausing there, when you use the term "structures", what do you have in mind?
A. What I'm really talking about is a level of governance, so number one, that joint executive meeting, but what we've now put on top of that is actually our boards agreeing that this is work we're doing together, and actually having that subcommittee, that board subcommittee, that has started just this year, 2024, and that's sealed with a collaborative agreement, which is based on the NSW Health and the Australian Government's joint statement.

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

Q. So you've got the structure in place. Where do you go from there in terms of future opportunities that you see for collaboration between the PHN and the LHD?
A. Well, I know you've heard evidence throughout the week around the patient-centred co-commissioning group, and I won't go into the details, but what I will say is that we started that work before COVID around the planning for collaborative commissioning, for those two chronic diseases - chronic heart failure and COPD - and it took us the best part of two years to actually land on, together with consumers, mapping that whole pathway.

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

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

Q. What do you regard as being proper planning for the delivery of either a collaborative project or an attempt to achieve a particular health outcome? What is it that you think proper planning involves?
A. Yes, it's important that we clarify that point. We were able to access a different kind of data, which is some linked and joined-up data from the health system and also from the primary health sector, so that we could truly understand, and it was again, preliminary days, but we could understand much more of that whole patient journey, not just their experience in our hospital.

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

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,

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

Q. So when you refer to a return on the investment, are you referring to a health outcomes return or a return in terms of a financial benefit and efficiencies within the LHD's service model?
A. It has to be both.

Q. How do you measure the former?
A. So the former is measured by process metrics, so things like length of stay in hospital, number of hospital admissions, things like that; number of presentations to the emergency department, complications. The health outcomes, of course, will take much longer to measure, and that's the evaluation that we're going through now.

Q. Do you feel at the moment with the data, the level of data that's available through, say, Lumos, that you do have a good sense or a good capacity to measure tangible health outcomes from the patient's perspective?
A. It's very hard to take it down to that granular individual patient perspective, I would say. It's probably easier to have a look at a group of patients from a particular area, because it's very complex data, you can appreciate. There were pockets of areas where there was greater disadvantage.

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

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

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

Q. For what duration, do you know? In terms of that HOPE information collected from patients as to their perception of the outcomes, is it immediately post admission and then for some period thereafter? Do you know?
A. Yes, we actually work that out for particular services. So for example, it might be done preoperatively, it might be done postoperatively and then three months later. It just depends on what the validated tool says you should do it. So it does differ. But there has to be a consistent approach across the state.

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

Q. Is there a way in which attempts are being made to mine that information or that data from the primary care setting to make an assessment of patient outcomes delivered through a particular intervention?
A. Yes. So we have started collecting patient reported measures through some of our general practices as part of collaborative commissioning. For that very reason, we need to actually measure the longer-term impacts of the patients when they finish with our service, yes. So it's early days, but we are now collecting that data, yeah.

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

than a metro LHD to collect that data through the primary health setting?
A. Oh, I do think that is true, and the reason is because, well, 100 of those doctors who work in general practice work with us as well, so we have a much closer relationship with many of them.

Q. So would you be bold enough to suggest that if there was money to be spent on piloting a collection and assessment of data through both the acute and primary care setting with a view to determining patient outcomes through a particular intervention, that regional LHDs like yours might be the better place to spend that money than, say, a large metro LHD which might have within its catchment hundreds if not thousands of GP practices?
A. I would not like to speak on behalf of my metropolitan colleagues. I was the joint chair of a working party under the joint statement, we're looking at regional planning, and I certainly --

THE COMMISSIONER: Q. What about if the question was: would a regional LHD like yours be a good place to do this?
A. Yes, that's a simple answer.

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

Q. -- what are they?
A. It is in relation to delivery of primary care, if I may --

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

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

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

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

Q. Is that, in your view, because the existing primary health infrastructure within some of those small communities is not sufficient to meet the needs of the community, the primary health needs of the community?
A. It's demand. There's too much demand, and after hours, we're it, after 5, and weekends, but also, if people - it is true that people cannot always get in to a GP when they need to in some of our smaller communities, and they may have to wait. So if they feel they can't wait, they'll go to the hospital as the other alternative.

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

Q. Part of it is also the historical fact that the medical workforce within those hospitals has traditionally been populated by GP VMOs from within the community; is that right?
A. That is right. The same GP that the patient can't get into, yes.

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

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

Q. Do you think there is scope within communities where the market based - existing market based system is not adequately providing for the primary health care needs of the community, for a salary based system to be introduced in order to better meet that need?
A. Just seeking clarification: are you talking about the need in the hospital or the need in primary care?

Q. Both. So to be blunt about it, to take a practitioner on a salaried model to operate within a small community as a provider of primary care through rooms, perhaps rooms attached physically to the hospital but not the emergency department, but also to continue to provide the role that was historically provided in that town perhaps by GP VMOs working through the hospital system - very much --
A. No, I understand the question.

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

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

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

Q. Would it be right that community by community, the situation and the solution will be very different?
A. Yes.

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

Q. Perhaps we'll come back to it, but incentivising a shift into those positions through increase in procedures through those small facilities, through that particular small facility?
A. Mmm-hmm.

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

Q. -- would it be right to say, or would you agree, that the appropriate way to approach the problem is to identify the needs and the solution as the first priority, and then work out who's going to pay for it and how it's going to be paid for in this collaborative way that you've discussed, as step two?
A. Yes. That's right. But it's not - it should not be an automatic assumption that the local health district necessarily employs that staff specialist. They could be

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

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

Q. Yes?
A. That is one model.

Q. That's one model?
A. Mmm.

Q. And again, community by community, the most appropriate might be different?
A. Yeah.

Q. But the starting point should always be identifying the need and the solution?
A. Yes.

Q. Rather than asking what the existing funding models, disparate as they are, might be able to deliver to a particular community?
A. Yes. It's my view that that needs that joint planning and it needs a framework - and we're actually working on one here through our precinct - should happen first; then the governance model; and then working out what it looks like within the existing resources, yes.

Q. And it's likely that an LHD will have a better understanding of the, in your case, 506-odd communities that you have --
A. Yes, 508.

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

Q. -- than a central authority? In terms of a process for identifying the needs and the best solution for the delivery of integrated primary and acute care in those communities, how do you think - from an LHD perspective - what structures do you think might the system introduce to mainly that to happen?
A. Because the other part of primary care that we haven't mentioned is the community nurses, the allied health clinicians that do the restorative care after the hip and knee replacement, healthy ageing, the preventative care, the - you know, the bit that we can do around, you know, home monitoring of patients with a chronic disease at home, so those --

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

Q. -- and then there is some hopefully successful mechanism by which the various parties that provide funding into health collaborate to deliver that solution?
A. Yeah, because the mechanism needs to be that in those communities, there is commissioned services from the primary health network, and then we have our own - the district has our own community nurses and allied health staff who are working in fragmented ways. So the mechanism around integrated care, which could be a framework, needs to mean that they all come together. Essentially what I'm saying is we need to break down the two systems and for these small communities it needs to be one mind set, one system.

Q. In a practical sense, how do you think we might go about doing that, and to the extent you have been able to do it in your LHD, if you have, how have you done it?
A. And, look, it's not for the faint-hearted. We actually have got in our collaborative commissioning project some staff who work for both the local health district and the primary health network. They do have a single employer, so we employ some and the primary health network employs some, but all the decisions - they come together and work as a team and all the decisions that are made are made in that group, together - can't happen one

without the other.

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?

A. We need to know about it.

Q. First of all, you need to know about it from a planning point of view; right?
A. Yes.

Q. Secondly, do I take it that you suggest the entity, potentially private commercial entity, that has brought that workforce in to the small area, might have a role to play in actually delivering the health care to that increased population for the duration of the project rather than the local - the existing market or --
A. Mmm-hmm.

Q. -- publicly funded?
A. It could look like that, or they could invest. There's a number of options.

Q. Again, that's just another tool that's potentially in the toolbox in order to deal with a bespoke solution --
A. Yeah.

Q. -- provide a bespoke solution for a small town?
A. Yes.

Q. One of the other critically important collaborators in all of this within your LHD are the Aboriginal community controlled health organisations?
A. Yes.

Q. RIVMED, GAMS, and I think there's a new one being stood up in Hay that we've been talking about?
A. Hay, and there's Cummeragunja, which is down on the border around Deniliquin.

Q. Can I ask what's the process that you have for collaborating with those organisations?
A. So with the primary health network, we have set up the Aboriginal consortium, of which they are members, and also there are other members of the consortium, such as the primary health network, but also some of their commissioned service providers, and also our service providers from within the local health district, and so that consortium comes together, meets regularly, and has a plan on what we think our agreed priorities are. Those priorities obviously are around improving health literacy, access to services and greater collaboration with us working

together.

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

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

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

Q. What do you think some of the big opportunities are in terms of improving the collaboration and the outcomes generated through that collaboration with the community controlled health organisations?
A. It is probably a flip around from the example that I gave because it is recognising the Aboriginal groups as the experts and the people with the knowledge about what their needs are. So in the work that we've been doing with another group, which is called - our local decision-making group, so RMRA. I'm just trying to think what it stands for - Riverina Murray Regional Alliance.

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

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

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

Q. From a process point of view, how is it that you go about obtaining from the community controlled organisation that guidance and direction in terms of where that - where, in their view, that money should be spent and projects should be delivered? What's the process of engagement that you have with them?
A. So the process of engagement is as much as we can having a formal agreement with them, if you like, an MOU or a heads of agreement. But I have to say that that's important, yes, because you can itemise some of those priorities, but what is equally important is developing a level of collaboration and trust. So we've focused on the collaboration and trust and we have some agreements with some of our ACCHOs and we're working on getting that formal agreement with others, but I can say that we would have made a lot of progress in the collaboration and trust space, and that takes time.

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

Q. -- two compatible personalities coming together?
A. No, definitely there needs to be a system approach to it. So there is always, we're seeking to have a working agreement with you, a heads of agreement, and we share our data. So we have created our own Aboriginal dashboard for our performance data and it measures some of the process measures, but it also measures things like our workforce numbers, 3.6 per cent of our workforce are First Nations,

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

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

Q. You started telling us a little bit earlier about your engagement with local government --
A. Yeah.

Q. -- as another collaborator. How does that work?
A. So once a quarter I make myself available to have a couple of hours with the mayors and the general managers. We do it on Teams. I would say to you that it started during COVID where I actually met with them every month and I probably spoke to many of the mayors and GMs regularly, as we had to stand up testing stations and vaccination clinics.

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

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

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

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

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

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

Q. Do you see the LHD as having a role in trying to harness some of that concierging of services that might best be delivered by a local council, for its own purposes - that is, say, to recruit nursing workforce to hospitals and the like?
A. Yes. So there are two parts to the answer. So there is actually a pilot project that is being - we're participating in with regional New South Wales, where in Griffith and Corowa there's a concierge approach to workforce. It's been really, really successful.

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

Q. Is that concierge service engaging with the local councils in the delivery of the service?
A. I do not know the answer to that. I would have to take that on notice.

Q. While we're on the recruitment, in terms of recruitment of staff to the smaller hospitals, who is responsible for those recruitment efforts in terms of the filling out of the forms and making the phone calls and the like? Take as an example, Berrigan?
A. Yes. So we've made some significant changes in our recruitment model and I think it was since 2021. Early in - in late 2021/22, the whole dynamics changed. So

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

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

Q. Possibly using a centralised advertising platform?
A. Yes.

Q. Received through that process, hopefully, some CVs and expressions of interest?
A. Yes.

Q. They needed to sift through them, interview the candidates?
A. Yes.

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

Q. And might involve a level of - some concierge services?
A. Yes.

Q. Possibly finding accommodation for the candidate?
A. Yes.

Q. So all of that, under the old system, was being done individually by facility managers at different hospitals?
A. That is correct.

Q. And just in those old days, was there any system in place for identifying whether the candidate who came second, perhaps, might be just as happy to work in Finley and might be referred to them as a possible recruit?
A. No. So there were significant delays in that process.

Q. What were the sources of the delays?

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

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

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

Q. Did it create economic efficiencies in the delivery of those recruitment processes as well?
A. Economic efficiencies? So we did actually have to put on a couple of extra staff to do some of that transactional work.

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

that work, did that free up more than two FTE's worth of time --
A. Over time and agency.

Q. -- in your community of hard-working facility managers and the like across the system?
A. Yes. Yes. I must say we haven't measured that, but that would be something, when we do the evaluation of our new supported recruitment that we call it, that we will definitely look to evaluate, because you could extrapolate also, if you got new people recruited, that you would reduce your overtime and your agency.

Q. So reduced the turnaround on recruitment, which meant candidates who got offered another offer somewhere else were actually being captured because the window of time in which that other offer might come in was smaller --
A. Mmm.

Q. -- potentially, with some efficiencies that are yet to be measured. What about an ability to potentially place a number of the applicants in other facilities around the LHD that the particular facilities manager - using our Berrigan example - might not have known was also looking for an RN or an EN?
A. Mmm.

Q. Was that also something that was able to be gained through the centralisation --
A. Yes, absolutely.

Q. -- at the LHD level?
A yes, absolutely.

Q. Have you found that that has worked?
A. Whilst it has worked, I think it's also accurate to say that there's still a big challenge in recruiting registered nurses with the skills and experience to work in those small hospitals. It is still very, very challenging, and that's to do with maldistribution. It's to do with whether people want to work in that environment as well.

Q. One of the things you've told us about in your statement is the Virtual Nurse Assist program?
A. Yes.

Q. Have you had any feedback on that program as to

whether it has been effective or it's seen as being useful by nurses who might not have thought about working in a remote area but have chosen to, despite that?
A. Yes, so we're - again, this was a deliberate effort to see if we could use early career nurses in our rural hospitals. The rule was previously that to work in an MPS you would need at least five years experience, and you would need to have experience working in an emergency department. So it was quite a change in the model for us to be able to allocate new graduate nurses to those facilities and make sure that they felt supported in the process, and clearly we didn't put them in charge in their first days there, but as time goes on, we've been able to support them.

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

Q. So you haven't yet done a formal evaluation but do you have any sense of whether it's had an impact on recruitment and retention in those smaller hospital sites?
A. Yeah, absolutely. So the feedback - I mean, the reality is, it would be quite daunting going - particularly if you're coming from a bigger centre, you know, a metropolitan health service, and you're going to a facility where you're the only nurse, and the message that we give people now is you're never the only nurse because there's always someone that is there that can guide you through a process. If it's a retrieval, we'll help manage the patient, but if it's just support you need around, professionally, how to undertake the triage or how to undertake a particular procedure, we can assist you with that. It's like having a nurse in the other ward, except they're virtual.

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

Q. -- through the service and the like?
A. Yes, we're capturing the data.

Q. Again, to the extent you've had some visibility of the data, has there been a large uptake? Is it regularly used, the service?
A. Yes, it's regularly used. I think we heard Dean say he'd like them to use it more, and I think, like anything new, people need to feel empowered to use it no matter what. They don't need to think that it's because they don't know something, it might just be to double-check that they're on the right track.

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

Q. You've given us a number of examples in your statement of ways in which that collaboration happens. Can I ask, how are those collaborations developed? Is there a formal process or is it history and ad hoc arrangements between clinicians who might have, say, been at university together or done their vocational training together who create these little alliances ultimately to the benefit of the LHD?
A. Mmm. It's a mixture of the two, actually, so --

Q. In the former case, what are the formal structures that exist?
A. So there's some formal structures around trauma, so we're part of a trauma network. Wagga Wagga Base Hospital is a designated trauma centre, and in the network, we collaborate with St George as our trauma receival hospital, and that is a formal network and there is collaboration and a formal process around that that happens.

Q. And that's because someone at a ministry level has looked at - the LHD, the services available through Wagga Base, has looked at St George and said, "Here is a synergy that we need to formally put - implement"?
A. All of the rural/regional local health districts are linked --

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

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

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

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

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

Q. We've heard a little bit about the challenges presented to people within the LHD when it comes to accessing specialist services within the LHD in an outpatient setting or in private rooms even. Do you see that there might be benefit in a needs analysis being undertaken in respect of particular areas of specialisation at some level, perhaps above the LHD level at a ministry level, with a view to creating alliances between hospitals within your LHD and metro based hospitals, with a view to delivering public clinics through the hospital setting, public outpatient clinics?
A. Absolutely. That would be very helpful.

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

those specialists working day-to-day, as, say, staff specialists?
A. Mmm, I think it's probably less of an issue, mainly because the Agency for Clinical Innovation have got some very sophisticated clinical networks and I know that a lot of our surgeons, physicians, and many of our specialty craft groups, actually participate in those clinical networks. They're very effective. They do all know each other, they share - you know, they talk about clinical variation, they look at innovation, they look at new models. So I actually think that those clinical networks that are run through the Agency for Clinical Innovation are very effective for our staff, our clinicians.

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

Q. Can I ask you to open up to page 27, paragraph 135.
A. 130?

Q. 135.
A. Yes.

Q. You tell us there about the financial incentives that have been introduced under NSW Health's Rural Health Workforce Incentive Scheme. Can I ask, has it been your experience that those incentives have been effective in reducing or at least easing some of the workforce challenges that you face in your LHD?
A. To some extent. They certainly have made a difference, and, you know, I was thinking of one facility manager recently up in, I think it was Hillston who has had a lot of success with the incentives.

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

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

those who might have been working there for a longer time who are not?
A. So I've made a deliberate effort, and the scheme allows for me to apply the incentive to all the staff who work in that service.

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

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

Q. But because otherwise accommodation within some of these communities would not be readily available to recruits?
A. That's right. We had an instance where we recruited a nurse to a particular middle-sized town and she arrived with family and children and was unable to find anywhere to live and we didn't have anywhere to offer and that person ended up moving to Wagga where they were able to find accommodation. So it was really then that we realised that we would need to do something to address the issue.

Q. That no doubt comes at a substantial cost to the LHD?
A. It comes at a substantial cost.

Q. But you, nevertheless, regard it as being necessary in the current climate to make some inroads --
A. Keep the service --

Q. -- towards dealing with workforce challenges?
A. It's about keeping the services open.

Q. Do you find that it's effective in that regard? Do you think the money is, to the extent it has to be spent, producing dividends in terms of your recruitment and retention efforts in these smaller towns?
A. It is very, very important, and it's the quality,

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

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

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

Q. At the other end of the spectrum?
A. That's right.

Q. But when you say some of the accommodation is not fit for purpose, what do you mean by that? I assume you're talking about the older accommodation?
A. Yeah, I am talking about the older accommodation. So most of our hospitals have got what we call the old nurses home, and bizarrely, nurses were once all women, for one thing, and they didn't seem to have families, and they were quite happy to share bathrooms. Well, that is no longer the case - any of those things. And so whilst that's essentially just a whole lot of very small single rooms with a shared kitchen and bathroom, that might be suitable for students that are just coming for a week to do a placement, they might be okay to do that, but it is certainly not fit for purpose.

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

Q. There's a priority, I assume, being given to the upgrading of those facilities?
A. That's right.

Q. Where does the funding for that come from?
A. So all of the new infrastructure builds that I've undertaken since I've been chief executive, we've included onsite accommodation as part of the project, and that money for Narrandera, Leeton, Finley and West Wyalong is part of, again, a grant allocation through the Ministry of Health.

Q. You told us a moment ago that it's not just about the money, and as you tell us in paragraph 138, the financial incentives are only part of the solution. When you say that addressing the problem comprehensively requires a holistic approach and following, could you just expand on that a little bit and tell us what you mean? What you have in mind?
A. Yes. So - which paragraph are you referring to?

Q. Paragraph 138, you see at the foot of page 27.
A. Yeah. So this is about people's career pathways. And again, it goes to part of what we need to be able to provide to people is opportunities to grow and develop in their career. So if you took a job at one of our very small MPSs, then what else is there as part of your career development, is what I'm referring to there. So is there opportunity to train as a clinical nurse educator - and many of them do that - or to go into become a clinical nurse consultant in a particular specialty area?

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

Q. So how have you, as an LHD, sought to provide those opportunities within that perhaps very small setting like an MPS in Berrigan?
A. Well, we've been very fortunate where we have received nurse strategy funding to be able to provide a number of career opportunities for nurses, and I think we heard in some of the evidence about some new funding that we've got for rural generalist nurse practitioners. So there, again, over the last 10 years we've had investment around every facility now should have a clinical nurse educator on staff, so that people can learn and grow while they're working, and that they can have that continuous education built in to their facility where they work - they don't have to go to Wagga for it. And so we've been fortunate. So there are a number of programs that we've been funded

for that nurses can develop their careers.

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

Q. Is that something that is on the radar of the LHD?
A. Yeah, very much so. I mean it is --

Q. What is being done about it?
A. It's a delicate balance, isn't it, around - it's probably reasonably easy to do with anaesthetics, so we've got quite a lot of rural generalist anaesthetists who can support doing lists in some of our district hospitals; same with palliative care; same with ED, mental health, obstetrics also.

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

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

THE COMMISSIONER: Sure.

MR MUSTON: Q. To what extent, if any, does the block funded nature of the smaller hospital settings disincentivise an increase in the number of procedures that are delivered through that small hospital - that is to say, there's no obvious inventive to generating more activity through a block funded activity as compared with, say, an activity based funded facility?
A. I actually don't think that it's - the impact is material in our case. What is more of a hindrance is the ability to find the perioperative workforce that goes with

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

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

THE COMMISSIONER: 1.45?

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

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

MR MUSTON: Q. I should make sure, is it convenient to you?
A. Yes.

THE COMMISSIONER: 1.45, then. Thank you.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, please continue.

MR MUSTON: Q. Can I ask you some brief questions about the Murrumbidgee "Growing Our Own" strategy that you've told us about in your statement. It starts at paragraph 140, if that's useful. First question, how long has it been running for?
A. So the grow your own strategy has evolved over a period of time. It's been running probably for 10 years.

Q. Has it been, to your observation, successful as a recruitment strategy?
A. It is the most successful recruitment strategy.

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

tracking the --
A. It is really just tracking.

Q. -- the careers of the individuals that have been through it?
A. Tracking the vacancies, yes.

Q. But is it tracking the career progress of those individuals who have come out of the grow your own program?
A. Yes, that's right.

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

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

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

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

Q. Newer but, so far, has it, to your observation, been effective?
A. It's been very effective, and I think probably the benefits of this program that you have seen we're doing in collaboration with Training Services NSW, who do fund a position also to assist in supporting those school students, it's a triple win, really, because, number one, they get to finish their higher school certificate, and many of them would probably not have gone on to do that.

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

Q. These are school students who are doing year 11 and 12 with a focus on vocational training rather than a progress towards university admission or the like; is that right?
A. Yes, that's right. So they can do either assistant in nursing or allied health assistant, and they come out with a qualification from TAFE at the end of it, and that then contributes to any further studies that they might do in the health sector.

Q. How do you go about promoting that program throughout high schools within the wider LHD?
A. So we've got two staff who work in the program and they go out to the local high schools during their career days and - but I think probably the work that they do with the career advisers in the schools and matching people up, and again, this is available in a range of high schools across the district, it's not just Wagga or Griffith. The students come from all over. And you can see that there's a high percentage of Indigenous students who also participate in the program - so 55 First Nations out of 101 that we've graduated.

Q. Can I take you to a slightly different topic now and just ask you some questions about the virtual care services that are offered through some of your community hubs. You told us that there's a - we have been told, I should say, that there has been some form of evaluation carried out as to the effectiveness of that program. Are you aware of that evaluation?
A. Are you referring to our remote medical consultations service?

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

remote medical consultation?
A. Okay, because they're all run out of - they're all run out one hub, if we're talking about the same thing, the place we visited in Wagga Wagga.

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

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

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

Q. -- where a doctor, usually a GP, will be Zooming in remotely to the emergency department to provide that emergency treatment with the assistance of the nurses on the ground?
A. That's right, yeah.

Q. In relation to that one, is there an evaluation process which is being undertaken in relation to that project?
A. Actually, all of it, if I could just say, because we run it as one service. The third component of the service, which we haven't talked about, though, is the patient transport, the non-emergency patient transport. It makes sense, in terms of efficiencies, to have the teams all joined and linked up because they can undertake mutual

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

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

Q. What does your own data tell you about the success of the program relative to whatever metrics you're applying?
A. In terms of effectiveness from a clinical perspective, it's highly effective, and in terms of patient outcomes, every day makes a difference in terms of outcomes. I mean, those patients once upon a time would have undergone long waits, ambulance trips, without having that sort of urgent treatment done at the regional site. So the clinical benefits are there to be seen.

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

Q. So the patient is in Berrigan, nurses and facility costs are Berrigan --
A. Yeah.

Q. -- allocated costs but the cost of the doctor who is Zooming in from Wagga, possibly, or somewhere else --
A. The nurse.

Q. -- is not a cost which is picked up as part of the allocation of funds to Berrigan?
A. It doesn't count as activity and it doesn't fit into any of our funding envelopes.

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

system or the funding model could be adjusted to better incentivise funding for health promotion and prevention?
A. It's a very wicked problem because, in actual fact, when the board and the executive and the staff are doing our strategic plan, this was a conversation that we asked many people, including the Commonwealth Government, because the reality is that the primary health network is not really funded either to do preventative care and, you know, we are obviously funded to run and operate hospitals and provide community services, but they're largely around case management of difficult patients. So who is responsible for preventative care?

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

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

THE COMMISSIONER: Q. What was the conversation with the Commonwealth Government about this?
A. Well, I guess to some extent, primary health networks have got flexible funding, and so - and every, I guess, general practitioner can do opportunistic preventative care, when you come in and you want to have your work certificate, but you end up having your blood pressure checked. So that was essentially the kind of information that we received.

But I do think that there needs --

Q. Sorry, does that mean the Commonwealth said, "Look, GPs can do this as part of doing an item on the MBS"?
A. (Witness nods).

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

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?

A. (Witness nods).

Q. I'm not sure whether it is still a premier's priority, but is it still a program that is being funded through --
A. Yes.

Q. -- at least the LHD in your district?
A. Yes. The Ministry of Health are still funding the program and it still occurs, and again, it's another long-term investment, I think, but it probably needs - it needs all lots of - it needs lots of people to intersect with a strategy like that for it to be successful.

Q. A whole of government issue?
A. Yeah.

Q. Are you aware of whether other branches of government within your district who you intersect with are continuing to fund and deliver the projects that were broadly brought under that First 2000 Days banner?
A. Other government agencies?

Q. Yes.
A. Yes, so definitely schools are one that I know about. I probably can't talk about others. Yeah, don't have a lot of visibility, although I have to say I do attend regional New South Wales meetings cluster, regional meetings with all of my counterparts, and we do talk about these sorts of strategies at a whole of government level.

Q. I think you've mentioned in an earlier answer issues around funding cycles.
A. Mmm.

Q. The funding cycle that you work to at the moment is an annual funding cycle?
A. That's right.

Q. And that present some challenges for you and the LHD in terms of rolling out programs over a longer period than 12 months?
A. That's right.

Q. How do those challenges manifest themselves in a practical way within the LHD?
A. So I guess if we think about the funding cycle, if we're going to - if we're going to implement something new,

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

Q. Is that in part a function of the fact that the budget that you can rely on getting year in, year out, is only just or perhaps not quite enough to deliver the essential services that the LHD has to deliver in an acute manner year in, year out, and so the funding for these projects is something that needs to be either separately allocated as a bonus to the budget or, alternatively, found as some spare money somewhere that you manage to squeeze out of something else?
A. That would be correct, because there's certainly not surplus in my budget at the end of the financial year.

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

Q. Which could be spent at your discretion on the advice of clinicians within the area and perhaps in consultation with the ACI?
A. Yes, it would be, and happy to acquit it in all the proper ways, but yes, it would be helpful.

Q. Can I ask you a very quick question about new builds, of which there seem to have been a lot in your LHD over the last few years?
A. Yes, we are fortunate.

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

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

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

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

Q. And under the activity based funding model, the activity remains perhaps the same?
A. Similar.

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

running the larger, newer hospital?
A. Correct. And just for the record, I understand that there is now funding that is allocated in the early days to help with that, so - yeah.

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

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

Q. -- in an appropriate way?
A. Exactly.

Q. In terms of decisions around whether to open a new hospital or refurb a particular hospital, those decisions often are largely political?
A. No, I wouldn't agree with that. So when funding is allocated, there's a whole planning process that you go through. So step 1 is the clinical service plan. Then step 2 is how can we deliver on that clinical service plan.

Q. Maybe we're at cross-purposes.
A. Sorry.

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

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

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

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

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

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

Q. In the SAM schedule?
A. SAMP.

Q. SAMP schedule?
A. Mostly.

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

Q. Patients from within the LHD flow between those borders. Is that something that creates any particular challenges or compromises the LHD's ability to deliver on the health needs of its community in any particular way, as you see it?
A. There are many challenges. So your question is?

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

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

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

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

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

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

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

a ministry level in both New South Wales and Victoria to iron out some of those wrinkles that you have to deal with?
A. We've got cross-border commissioners in the mix as well, also. Look, I don't think I can answer that question because I don't have enough visibility about what our various departments - and what that interaction looks like.

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

Q. Well, I'm very happy to pass you the wand or, the Commissioner likes the wand, I prefer the genie's bottle, but we'll give you both and you can make your own choice.
A. I think that because we have the historical way of providing services to the community, the local health districts are doing what we did in 1980, you know, we're still running an ED, we're still running a hospital, and we've always had aged care, and now we've morphed into an MPS, and that works well.

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

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

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

Q. If you were given all of those funds from the various disparate sources that find their way one way or the other into the delivery of health care within the community and they were dropped into a single budget under your control, how would you go about designing the best model for the delivery of health care in a community, accepting that each community will have a slightly different model which will work for it, but what would your approach be?
A. Well, it would be, you know, obviously the health needs assessment, so you work out what people need, and then you work out what the workforce is. If you recall earlier, I said we're having trouble attracting people to work in our current model, but if you can imagine that all of the workforce comes together so that instead of the social isolation within their profession now they've got colleagues, and you've got a cohort of people that are really there for one purpose, which is to develop - to deliver health and social needs to their community, and you've got a cohort of people with one purpose, and you allocate your workforce in accordance with the needs of the community. And it's always going to be in those communities about healthy ageing, how you support people to stay at home, you know, if you've got a social care provider in the mix then that can be worked through. There's mental health issues, there's a lot of depression attached with being on your own and ageing. There's youth - so there's a whole range of things, but I could imagine that it would be easier to attract people to work in a collaborative integrated model than in the current models that we're trying to fill the gaps with.

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

Q. You're just going to know, and other parts of what are the health needs of your population, really good data is going to help?
A. Yes. I think so. The health needs assessments that are undertaken by the primary health network include things like access to internet, and all those things are actually really important, and then if you combine that with, you

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

MR MUSTON: Q. So is the starting point in the perfect world, you sit down with all of the money that's available, potentially in a particular community, you take your health needs, and you look to build as an integrated model the best healthcare service for the delivery of health care in that community, utilising the funds that are available in the most effective way?
A. Mmm. And, you know, I think, though, we need to understand that that wouldn't be continuation of what we're currently doing, it would look different.

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

Q. It's the collective responsibility of the group to deliver for the health needs and their pooled resources would be used for that purpose?
A. Mmm. I think at the core of that model would be aged care, some sort of provision of aged care, whether it's residential or community based, and also some level of primary care and urgent care, because the majority of the work that's being done in our emergency departments is actually urgent care, and urgent care and primary care can be done by a general practitioner and nurse practitioner.

Q. And urgent care, as distinct from what might be regarded as genuine acute care delivered through an emergency setting?
A. Yes. And then, you know, if we've got our then bigger towns with their emergency departments, they're going to have the volume of activity to support the specialist workforce that we need in there as well, so then you have your busy and vibrant EDs that are not so far away and you have your urgent care and your aged care services supporting the community, along with your integrated allied health team supporting healthy ageing and chronic disease management.

Q. Can I ask you to put the wand down for a minute. I'm going to ask you some questions about procurement.
A. Right. Sure. That's a disappointment.

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?

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

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

Q. As do you as an LHD. Is there an issue associated with the pass-through nature of the costs that the incentive to find efficiencies and savings within the delivery of those services doesn't rest with HealthShare, if they, responsible for the delivery of those services, can then pass on the full costs of them to the LHDs and, nevertheless, still potentially bring themselves within their budget?
A. So the reality is what you're saying is correct, but I want to put a caveat on it, which is that HealthShare work in partnership with the local health districts in a true way, and we have raised with them that we would like to look at some, I guess, greater efficiencies in some of the support service models that we have, and it's always the small sites where we're talking about a labour market, really, and the costs around the cooking and cleaning are largely around the labour, and so we're very keen to engage with them to do some work around what would a more efficient model look like, how could we rearrange it, and they're very eager and keen to do that. So I just want to say that that's important and we're about to start doing that work. Yes.

Q. In relation to the shared services that are not strictly volume based - when I say "volume based", food obviously is a volume based service; linen is a volume based service - but some of the others like the transactional and payroll services are not volume based?
A. Some are, some aren't.

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

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

a cost but, rather, provided by HealthShare through a budget delivered to HealthShare within which it has to deliver that service system-wide - payroll, for example?
A. Yes - well, for me it would make my life so much easier, and I'm just trying to think of, then, where are the opportunities for the improvement? So the opportunities for improvement would then sit with HealthShare, yeah.

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

Q. HealthShare delivers those services and then works out a way, as we understand it, of sharing the total cost of delivering those services to the system across the system by, in the case of payroll, say, dividing the total cost by the number of employees on the payroll and divvying that up between LHDs on a per employee basis?
A. Yeah, there would need to be a partnership, because - I'll just use an example.

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

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

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

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

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

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

Q. Can I ask you quickly about paragraph 119 where you say "improved pharmaceutical inventory management system would be an opportunity for the district"? Could you just explain briefly how that opportunity might work?
A. Yes. So we know about DeliverEASE and the success of DeliverEASE. DeliverEASE does not include pharmacy items at the moment, and in the procurement reform, where they've got procure-to-pay coming up in the reform process, it's going to tidy up that whole back end of the pharmacy, which is all very manual and labour intensive at the moment in matching tax invoices and batches off to HealthShare for payment. So that's all going to get tidied up and we welcome that when it comes along, and our pharmacists are already engaged in that change process.

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

Q. Under the current arrangements do you have an ability to, say, look at a particular medication that you might have sitting in the pharmacy at Berrigan and recognise that it's not often used and about to go out of date so perhaps we should ship it up to Wagga where they use it more frequently?
A. No.

Q. And when you talk about improvements in the inventory

management of pharmaceuticals is that --
A. Yes.

Q. -- one of many things that you think might be a good feature?
A. Yes.

Q. It'd prevent wastage and also in times of surge enable you to make sure you are --
A. Absolutely.

Q. -- able to find every last box of that particular medication that you might need?
A. Absolutely. And every time there's a new contract let, they've got to go in manually and sort of input that data into the iProcurement system, the i.Pharmacy system, so, yes, possible opportunities there.

Q. Can I just change subjects a little bit to service planning. At a general level, how are decisions made in the context of, say, a rebuild or a refurb, like in Finley, as I understand one is on the cards?
A. Mmm-hmm.

Q. How are decisions made about which services to deliver through the budget that has been allocated for the refurb of that hospital? So, that is, how are decisions made about whether an operating theatre should be included as part of that rebuild as opposed to a renal chair or - they might be poor examples but hopefully you get my drift.
A. Yes, I do. I do understand. Those decisions should be made when we do the clinical service plan, before we get into the infrastructure design, because if the activity isn't there for renal, then that would be articulated in the clinical service plan.

Likewise with operating theatres, if, when they looked at the activity in that particular region, it was determined that there was insufficient activity to support perioperative services and that people from that region would be better off accessing them from another centre, that should be articulated and must be articulated in the plan, because the clinical services plan is what informs the build.

Q. It should inform the build. In your experience over the last decade, has it always informed decisions around

the build?
A. It has largely, absolutely. Yes.

Q. And are those assessments made, and I gather from an answer you made a moment ago that they are, but to confirm, those assessment are made in a systemic way so that you look - dealing with, say, renal chairs, you look at where renal chairs are in and around the facility in question, with a view to determining whether adding one in that particular facility would be a necessary and appropriate thing, having regard to the needs of the community as they've been assessed for that service?
A. There's software that looks at population projection increases, and often it's the population figures that we have the most disagreement with, with local council, actually. And I think that's generally across the board with many things and they count their population slightly differently than the ABS, because they look at development applications in the pipeline, whereas the bureau of statistics doesn't.

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

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

Q. How are decisions made in those instances as to what should be prioritised? Does the software give you a ranking of what there should be or are there some hard decisions to be made there?
A. No, it does not. There are hard decisions to be made there. I guess what we would always try and do in a building where that happens - because money is always tight - is to do a value management process where a number of stakeholders come together, and I've been involved in

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

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

Q. -- that can be derived through a particular service over another?
A. Yes.

Q. How are they measured or estimated?
A. So in the value management process, we would always look to see where we could cut down on the actual physical infrastructure to continue to provide the number of beds or the number of chairs. That's how we - that's generally how we do it. We might say, "We'll have three less meeting rooms, so that we can have three more beds over in that ward, which we can't have in the current funding envelope."

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

Q. Can I ask you one last question. You've told us a lot about what's working really well in the LHD. We've also talked about a couple of the wicked problems, but are there things that we haven't mentioned that you think are not working particularly well in terms of the delivery of health care within the LHD that could work better if systemic change was made at any level and, if so, what are they and what's the change that - picking up your wand again - you would invite us to recommend?
A. Oh gosh. It would probably be in the mental health space. The needs for mental health in rural communities are really quite high, and in many circumstances, a lot of the mental health patients are not known to our service, because they are largely being treated in primary care, and

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

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

MR MUSTON: Thank you.

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

THE COMMISSIONER: Thank you. Mr Chiu?

MR CHIU: I have no questions, Commissioner.

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

THE WITNESS: Thank you, Commissioner.

THE COMMISSIONER: You are excused.

<THE WITNESS WITHDREW

THE COMMISSIONER: That completes these hearings.

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

THE COMMISSIONER: It is some time in April.

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

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