# Special Commission of Inquiry

# into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Dubbo RSL,
Cnr Brisbane Street & Wingewarra Street,
Dubbo, New South Wales

Wednesday, 15 May 2024 at 9.30am

(Day 027)

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| Mr Ed Muston SC | (Senior Counsel Assisting) |
| Mr Ross Glover | (Counsel Assisting) |
| Dr Tamsin Waterhouse | (Counsel Assisting) |
| Mr Ian Fraser | (Counsel Assisting) |

Also present:

Mr Richard Cheney with Mr Hernan Pintos-Lopez for NSW Health

1 THE COMMISSIONER: Good morning, everyone. Are we ready to
2 take Dr Hua? I think we are.
3
4 DR HUA: Good morning.
5
6 THE COMMISSIONER: Can you hear me, Dr Hua?
7
8 DR HUA: Yes, thank you.
9
10 THE COMMISSIONER: Would you like to give your evidence by
11 way of oath or affirmation?
12
13 DR HUA: Oath, please.
14
15 **<MARTIN HUA, sworn: [9.30am]**
16
17 **<EXAMINATION BY MR MUSTON:**
18
19 MR MUSTON: Q. Could you give us your full name for the
20 record, please?
21 A. Yep, Martin Hua.
22
23 Q. You are the acting rural health director of medical
24 services in the Western NSW LHD?
25 A. Yes, that's right. I've got a few other hats. I'm
26 also one of the co-clinical leads for the Virtual Rural
27 Generalist Service and I'm also a GP VMO on the ground.
28 I look after a couple of towns, Baradine and Coolah.
29
30 Q. Could I ask you quickly about practising as a GP in
31 Baradine. Let's start with the community itself. It's
32 a small town in the Pilliga scrub?
33 A. Yes.
34
35 Q. According to Wikipedia, it has a population of about
36 600 people. Is that accurate to the best of your
37 knowledge?
38 A. I feel - I think in the past couple of years I would
39 hazard a guess that that population has increased. We also
40 have a couple of sort of satellite towns that we capture,
41 so just a little bit north of us there is Kenebri and
42 Gwabegar and then a little bit to our east there is
43 Bugaldie. So I would say that our catchment probably is
44 closer to maybe just over 1,000 people.
45
46 Q. So when you say that, that's the catchment of the GP
47 practice that you operate in town?

1 A. Yes, as well as the hospital.
2
3 Q. Are you the only GP practice in town?
4 A. We are the only GP practice, but my wife is also a GP
5 and so we share the job.
6
7 Q. And do you practice only out of Baradine, or do you
8 have an outreach, as it were, into some of these other
9 communities around Baradine?
10 A. Yes, so our GP practice is only in Baradine. We do do
11 a bit of outreach into residential aged care facilities, so
12 that includes Gulargambone, Gilgandra and Coolah. So
13 sometimes that involves a close to 400K circuit.
14
15 Q. Are those aged care facilities associated with MPS
16 facilities in town?
17 A. At present, yes, yes.
18
19 Q. I think you have told us you are a VMO also practising
20 into the Baradine MPS; is that right?
21 A. That's right. And Coolah.
22
23 Q. Could you just describe, perhaps one at a time,
24 starting with Baradine, just the nature of the services
25 that are offered at those two MPS sites?
26 A. They are very similar. So we offer an emergency
27 service through the Baradine MPS; there is four to five
28 acute beds for acute inpatients, depending on staffing
29 levels, and then, look, off the top of my head, I believe
30 it's 13 aged care beds in Baradine and 20 aged care beds in
31 Coolah.
32
33 Q. Can I take you back to your LHD roles. Firstly, your
34 role as rural health director, medical services, what does
35 that role involve?
36 A. Yeah, sure. I'm only very new to the role, so I've
37 only taken on the role, if memory serves me right, towards
38 the end of February, early March. I can't remember the
39 exact date. It mainly involves sort of providing the
40 medical input into issues that arise operationally across
41 the non-procedural peripheral sites. So I don't have any
42 expertise around things like anaesthetics and obstetrics,
43 so I've kept my distance from the procedural sites, so it's
44 only the non-procedural rural sites that I assist with, and
45 basically, if I'm to be frank, mainly it's, you know,
46 liaising with VMOs, you know, listening to their concerns
47 and trying to address them as much as I can.

1
2 Q. In that role, to the extent that you have had liaison
3 with VMOs so far, what are the nature of some of the
4 concerns that they have raised with you? Are there common
5 themes?
6 A. There are. One of the themes that has been raised is
7 around other health professionals and their scopes - scope
8 of practice and how that might interact with the
9 traditional scope of practice that a GP would expect to
10 have in a rural community. They have raised issues around
11 workload and such and, then, you know, you can't get away
12 from it, remuneration.
13
14 Q. Let's go through them one at a time, if we can. The
15 concerns that they have raised about scope of practice or
16 an expanded scope of practice for non-medical staff, is
17 that an expanded scope of practice of non-medical staff
18 working in the MPS, at the MPS sites?
19 A. Yes. So there is a couple of things there. I think
20 the first is, yes, you know, the expansion of sort of
21 non-medical staff and their scope in MPS sites, but I guess
22 also from my own personal perspective, if I may, also the
23 potential expansion of scope of practice of non-medical
24 officers in the community.
25
26 Q. By which you mean pharmacists?
27 A. Pharmacists and I think, reading the sort of medical
28 media, we do expect at some point increased scope of nurse
29 practitioners in the community and access to - and I mean,
30 look, I'm not going to lie, I don't have a thorough
31 knowledge of nurse practitioners and their access to
32 Medicare, but I believe that, you know, there will be
33 greater scope of access in the future.
34
35 Q. So in terms of the concerns that are being expressed
36 to you by VMOs, are they concerns about the ability of
37 those professionals to deliver service within what might be
38 the potentially contemplated scope, or is it more a concern
39 about the impact that that expansion of scope might have on
40 the viability of a GP's business in a small community like
41 yours?
42 A. Yeah, so there is - again, I'm going to split that up
43 into two parts, if I may.
44
45 Q. Please.
46 A. The first part is there have been some concerns raised
47 by my colleagues around the ability of our nurse

1 practitioners, for example, in an MPS site, to offer the
2 same degree of clinical acumen as a medical officer would,
3 and I think part of that is the - I guess, you know, the
4 way that it's been explained is that, you know, to become
5 a medical officer, you go through university, you do your
6 prevocational training, you do your X years of fellowship,
7 and then you are allowed to practise independently, and
8 through that, you gain a lot of practical experience, and
9 that might not necessarily translate into non-medical
10 colleagues practising in the MPS.
11
12 I don't necessarily - I personally don't necessarily
13 agree with that. The nurse practitioners that I've worked
14 with, and you have to bear in mind that this is anecdotal
15 and personal experience - the nurse practitioners that
16 I have worked with have all been very competent. They have
17 all sort of tried their best and, you know, tried to do
18 what's best for the patient. Now, that doesn't necessarily
19 translate to all people in that cohort. I might just be
20 lucky and I might just have come across ones that, you
21 know, are the cream of the crop. But coming back to my
22 colleagues' concerns, then, I think it comes back to issues
23 around safety, clinical governance and just whether or not
24 patients are receiving the same level of care as you would
25 if you saw a medical officer.
26
27 Q. Can I be so bold as to ask this question: your
28 experience of nurse practitioners, the nurse practitioners
29 that you have dealt with, has, as you have told us, been
30 good. Is it possible that there is also a significant
31 level of variability in the quality of service delivered by
32 individuals with medical training and qualification across
33 the board?
34 A. I'm sorry, can you repeat that question for me,
35 please?
36
37 Q. Is it possible that that - do you accept that there
38 may be a significant degree of variation in the quality of
39 the service which is able to be delivered by some
40 individuals who do have medical qualifications and
41 training?
42 A. Yes. That's absolutely correct. I mean, in all
43 occupations I think that's - there is a spectrum. That's -
44 yes.
45
46 Q. The key issue there is, to the extent that a workforce
47 is being utilised, ideally you want to be utilising the

1 workforce, whatever the qualification might be, that is
2 best able to meet the needs of the community that they are
3 intending to serve?
4 A. Sorry, was that the end of the question?
5
6 Q. Yes, it was.
7 A. I think there is a longer answer to that question and
8 I think - so, you know, if you have nurse practitioners
9 moving into a lot of the work that GPs - look, I think
10 there is a couple of ways to look at this, right? The
11 first way is, you know, how it's been pitched, and the
12 second way is what are the long-term effects of this. So
13 what I mean by how is this pitched is that, you know, every
14 other week or every other month, if you read the newspapers
15 or if you read the medical media, things like Medical
16 Republic or AusDoc or things like that, every other week or
17 every other month, there is some kind of negative thing
18 about things affecting GPs, right? So, you know, the
19 perception around nurse practitioners - what I want to say
20 about that is that, you know, if you are a junior doctor,
21 as an intern or as a resident, right, and you are thinking
22 about your future career path, and every other week and
23 every other month you see something like, you know,
24 "Pharmacists prescribing", or "Nurse practitioners working
25 under Medicare", and there are these concerns around their
26 scope and perhaps a breach of their scope into GP world,
27 you know, that's going to affect how you view GP, general
28 practice as a career and as a vocation, right?
29
30 I think that is sometimes missed when we talk about,
31 you know, expanding the scopes of our colleagues. Like
32 I said, on my experience with my colleagues, nurse
33 practitioners, pharmacists, they've been great. But I want
34 to - I step back and I want to put my mind into one of my
35 junior colleagues, and every other week or month they see
36 something like this and, you know, I have no doubt why they
37 wouldn't necessarily view general practice or rural
38 generalism as a potential career path.
39
40 So, you know, coming back to the question, then, the
41 longer term effects of this, right, yes, sure, we're
42 treating the symptom of access now. We're providing access
43 now to nurse practitioners, some of whom are great and will
44 provide, you know, great service to these underserved
45 communities. But what's the longer term impact of this?
46 We're not treating the underlying cause, right? And the
47 underlying cause is, you know, primary care and GPs in the

1 community. I think that that sort of - I don't know if
2 it's subtle or I don't know if it is sort of tangential,
3 but I don't think that - to me, it doesn't feel like that's
4 being considered as much, how this is being viewed upon by
5 my junior colleagues, when they are choosing their future
6 career paths.
7
8 Q. So when you say the underlying cause is primary care
9 and GPs, you are referring to the fact that the
10 availability of primary care and the number of people
11 willing to come and work as a GP in areas like yours is
12 dropping off?
13 A. Yes, look, I think about - I'm going to say about
14 three years ago, I might be a little bit off on my dates,
15 there was a period where I was, you know, intending to move
16 on and, from memory, there was about a three- to six-month
17 lead in, into sort of my - like, you know, that period
18 where I had said, "Look, I'm probably going to move on",
19 and the date that I was expecting to move on. I think
20 there was one other person who came in and had a look to
21 see if they wanted to do it, you know, saw what it was like
22 and promptly sort of ghosted the community, really. You
23 know, didn't sort of inquire or follow up on their
24 interest.
25
26 I think a lot of our smaller towns that really would
27 sustain only one full-time equivalent general practitioner,
28 they would probably face a lot of sort of similar sort of
29 experiences.
30
31 Q. I think we covered concerns around the ability of
32 allied health working professionals and other clinical
33 professionals having an expanded scope. What is the
34 concerns or what are the concerns that have been shared
35 with you around the impact that that might have on the
36 viability of a GP's business in a town like yours and the
37 desirability of coming and setting up practice in a town
38 like yours?
39 A. Yes, sure. I think to provide a little bit of
40 context, my town is, with all due respect to my town, not
41 an affluent town. In terms of income, it's probably in the
42 bottom quartile, right? So we're a fully bulk billed
43 clinic. And so I think when it's been pitched about sort
44 of - look, I'm going to use pharmacists prescribing for
45 UTIs as an example, because I think that's been very
46 recent, I think there has been some media in the past
47 24 hours about it. Now, a pharmacist prescribing for

1 a UTI. Now, a consultation by a GP for a urinary tract
2 infection might be considered a straightforward
3 consultation, and you could probably complete that, you
4 know, reasonably well.
5
6 If I had my practice nurse do a urinalysis and then
7 the patient came in, did a history, did an examination, in
8 GP land, you could, you know, reasonably do that in
9 10 minutes, right? And that's a straightforward
10 consultation. You know, young person comes in, classic
11 signs of urinary tract infection. History, examination,
12 UA, exclude other causes. Ten minutes, right? And then
13 that's on one end of spectrum.
14
15 And so I think the comment that I read was that this
16 is meant to take the pressure off GPs and, you know, our
17 workload. But the thing is that we do a lot of sort of
18 complex cases as well, which aren't as well remunerated,
19 and sort of mentally can be a lot more taxing. Often
20 times, in practice, what you might do is you have a complex
21 case, and the sort of opportunity cost of doing a complex
22 case is offset by more straightforward cases.
23
24 And so I will give you an example, right? If someone
25 came in with heart failure, non-compliant with medications,
26 not really engaged with, you know, medical care, just by
27 personal preference - you know, that consultation can
28 easily stretch to half an hour to do appropriately -
29 history, examination, appropriate investigations,
30 appropriate referrals, explanation of why you need to do
31 these investigations and go to these referrals. Now, half
32 an hour consult is like a level C under Medicare. Now,
33 level C, if you are not bulk billing, I can't remember
34 exactly, it's about $80, right? Sorry, that's without the
35 bulk billing incentive.
36
37 Now, you know, a level B, which is a less than
38 20-minute consultation, which a urinary tract infection
39 could come into, is $40 if you are not bulk billing - there
40 or thereabouts. And so if you can imagine, you might have
41 this very long consultation that might only get you $80,
42 and the opportunity cost of doing that consultation you
43 would offset by, you know, less complex cases. And so what
44 you might have then is like, you know, the idea that you
45 are sort of taking the load off, I'm not necessarily sure
46 that, you know, that is always going to be to the benefit
47 of the GP.

1
2 I mean, the other thing is that sometimes these less
3 complex cases provide you with a bit of a mental break, if
4 you will, from the complex cases. I mean, can you imagine
5 just sort of sitting down, like, you know, 30-minute
6 consultations throughout the day, just doing sort of
7 explaining to people about what heart failure is, what
8 their lifestyle is doing to contribute to heart failure,
9 you know, why they need to do these investigations and
10 tests, hear the push back of why the person doesn't
11 necessarily want to do the test. To do an echocardiogram
12 in Baradine, right, it is a four and a half hour round trip
13 to Dubbo, right?
14
15 That's a lot of mental juggling and sort of empathy
16 that you have to put into that kind of consultation. And
17 not to say that, you know, I don't put any mental load into
18 a urinary tract infection consultation - these are just
19 examples, by the way - but you know, a straightforward
20 consultation like a urinary tract consultation does sort of
21 ease the mental load a bit. You know, it gives you that
22 little bit of a breather so that you can continue on with
23 your day.
24
25 Heart failure is probably not a great example.
26 Probably a better example that all GPs face in the
27 community, I think, is chronic pain, right? A chronic pain
28 consultation and how to manage it in terms of, like, the
29 mental aspects of it, the physical aspects of it, the
30 socioeconomic aspects of it - that consultation, you know,
31 can easily go 30 minutes. It wouldn't quite get you to
32 a level D, probably gets you to a level C consult. But
33 that's - as I said, there is an opportunity cost to that.
34
35 I mean, it sounds - I don't want to sound awful and
36 just put, you know, medicine down to economics and money,
37 but, you know, at the end of the day, for example, Baradine
38 surgery is a small practice, it is a small business, right?
39 I want to care for my patients but I still need to pay
40 salary and wages, the rent and all that kind of stuff.
41
42 Q. The next issue that you have told us your VMO
43 colleagues have raised with you is workload. Is that
44 workload within their practices, within the hospitals, or
45 some combination thereof?
46 A. I think it is - mainly the colleagues that I've been
47 speaking to have been around the VMO work. More lately,

1 it's been sort of positive comments, especially around, you
2 know, the use of VRGS, or the Virtual Rural Generalist
3 Service. As I said earlier, I'm one of the co-clinical
4 leads so I don't want to sound biased, but from a personal
5 perspective, I can speak to it from a personal perspective
6 because I'm also an end user on the ground, and the
7 comments that my colleagues have given sort of mirror what
8 I have said. So my standing arrangement is that I will
9 cover category 1 to 5 consultations via the ED between 8am
10 and 8pm. Between 8pm and 8am, I'm around for category 1s
11 and 2s, and VRGS covers me for categories 3 to 5s.
12
13 What I have noticed between - so I've been around pre
14 VRGS and post VRGS. So the thing is that pre VRGS, what
15 you would do is you would have a whole clinic day, you
16 know, see 28 to 30 patients and, you know, that's 28 to 30
17 sets of individual problems that you deal with during the
18 day. Whatever comes in via the ED through the day you have
19 to deal with. And then you would sort of go home at about
20 6, 6.30, sort of get ready for tea, and then you might get
21 called out at, you know, 8 o'clock and you think "All
22 right, great, this is my one call out of the night."
23 Because statistically speaking, you might get one or two
24 call-outs - you know, not statistically speaking but
25 anecdotal experience, you might get one or two call-outs.
26 So you might get called out at 8, you don't get back till
27 9. By the time you settle in again it's 10 o'clock. You
28 fall sleep and then you get called again at, you know,
29 2 o'clock in the morning.
30
31 Now, you have had sort of five hours of sleep there,
32 your body thinks it is rested. You've been woken up. You
33 don't necessarily need to go into the hospital but you've
34 been woken up, right? Once you have been woken up after
35 that period, it's very hard then to go back to sleep. So,
36 you know, I found that pre VRGS I was probably getting, you
37 know, four, five hours of sleep consistently through the
38 night, and I would sort of go to bed at night sort of a bit
39 stressed as to whether or not I would get a full eight
40 hours of sleep. Coming into the weekends - sorry, I didn't
41 do Saturday and Sunday on calls then.
42
43 Coming into the weekends it was great, because I knew
44 I could get eight hours of sleep. But that kind of wears
45 away at you very quickly, and so since VRGS has come in,
46 you know, I've been able to be reasonably guaranteed eight
47 hours of sleep every single night. It doesn't sound like

1 a big deal, but I can assure you, it is a very, very big
2 deal. And the thing is that knowing my colleagues, knowing
3 the service that they provide, you know, I don't think
4 that, for most presentations, my personal experience is
5 that I don't think necessarily that there is any huge
6 difference between my virtual colleagues seeing some of the
7 lower acuity cases overnight and me doing it overnight.
8 And so, you know - look, I don't know if that answers your
9 question, but across time it's made a difference.
10
11 Q. I think it does. The last issue that your colleagues
12 have raised with you, you tell us, is remuneration. Again,
13 is that remuneration through the MBS in their practices,
14 remuneration for the VMO work they're doing or, again, some
15 combination thereof?
16 A. Yes, so I think it's a bit of both. I think there is
17 always a little bit of unhappiness around the -
18 "unhappiness", I don't know if that's the right word -
19 around what the Medicare rebates are and then sort of
20 deciding about whether or not to bulk bill or to not bulk
21 bill, and look, of late I have sort of had a lot of
22 inquiries about my - from my VMO colleagues around, you
23 know, their remuneration levels at the MPS sites.
24
25 Some of it's not always realistic, you know, some of
26 them might be. But, you know, I think what it comes down
27 to is just, you know, they want to be remunerated for what
28 they do. They don't want to necessarily be seen as
29 a second-class citizen, if you will, when it comes to
30 remuneration. I think if you look at the sort of VMO rates
31 under the sessional contracts, there's a difference between
32 GPs and non-GPs, and, you know, generally speaking, GPs
33 don't have access to staff specialist contracts.
34
35 Q. In terms of the VMO remuneration that is received, is
36 the ability to access that money something which, at least
37 in a community like yours, is necessary to render the
38 practice, the otherwise GP practice, viable?
39 A. Yes, absolutely. Like all small businesses, you have
40 bad quarters. Knowing that you have got a reasonably
41 steady income from the MPS sort of offsets it. I would
42 hazard a guess that between my wife and I, you know, the
43 majority of our income, you know, even since the Medicare
44 triple of bulk billing in November of last year, even since
45 then, the majority of income comes via the state system,
46 through the VMO work.
47

1 Q. Based on your discussions with colleagues who are in a
2 similar position to you in smaller communities, do you have
3 a view on the long-term viability of what might be called
4 the traditional GP VMO model for delivering both primary
5 and acute care in a community like yours?
6 A. Yeah. Look, to put it into - like can I just put it
7 into purely financial terms? I mean, there is the mental
8 load, right, and that's in and of itself difficult to be
9 one, full-time doctor. I'm lucky because I have my wife
10 and we share the load here, but if you had one sort of
11 full-time person on the ground with the mental load of a
12 thousand people's different worries, it is a huge mental
13 load.
14
15 You know, in terms of the actual remuneration, I think
16 if you were fully bulk billing in a town like ours, I don't
17 think you would last. I think the income that you get from
18 just - just the GP, right, just the Medicare GP practice,
19 after costs, you know, you'd probably be looking at
20 something not much more than what I registrar might make in
21 a tertiary hospital, right? And so what really makes it
22 financially viable is the fact that you do have the MPS
23 work to supplement it.
24
25 Q. In relation to that, so that is making the practice
26 viable at the moment, but if you sort of - projecting into
27 the future, do you think that the viability - do you thank
28 that model has long-term viability, for example, in your
29 town? Obviously each situation will differ.
30 A. Yeah. Look, can you explain that question a little
31 bit more for me? Sorry, I'm not sure if I understand
32 correctly.
33
34 Q. Perhaps let me look at it another way. If you left
35 tomorrow, do you have a view that there would be anyone who
36 would step in to take up your practice, supplemented by
37 what income could be received through working as a VMO in
38 Baradine hospital and other small MPS sites?
39 A. Not necessarily, I don't think. You know, as
40 I alluded to earlier, when I wanted to leave about three
41 years ago, they had - you know, I think if you look at
42 income and cost of living, it was probably comparable, like
43 if you translate it, and there was one person who looked
44 and that person walked away, you know? I don't think
45 that - I don't think it's necessarily all that viable.
46
47 I think when I was thinking about that, during that

1 period, not trying to plug what the LHD is doing, but
2 what - during that period I tried really hard to sort of
3 convince the DMS at the time to make Baradine like the
4 Four Ts model, but I don't think it was a plausible option
5 at that peculiar point in time.
6
7 Q. When you say "not plausible", for what reason do you
8 think it was not plausible?
9 A. Look, I don't know the specifics. I think it - look,
10 if I was to hazard a guess, I think it was - at the time
11 the Four Ts was only a pilot trial, and so, you know - and
12 I was leaving in three months or whatever, and there
13 probably just wasn't the turnaround time or the - for all
14 the sort of bureaucracy and logistics to organise it. But,
15 you know, it would have made my decision to stay a lot
16 easier if we had moved to a Four Ts model in Baradine at
17 the time.
18
19 Q. I will come back --
20 A. I still stand --
21
22 Q. I will come back to that. Just quickly, your role as
23 one of the clinical co-leads of the VRGS service, could you
24 just give us a little bit of background as to what that
25 involves?
26 A. The role or VRGS?
27
28 Q. Let's start with VRGS. Give us a potted description
29 of VRGS.
30 A. So, I mean, it's exactly as it sounds. We're virtual
31 rural generalists serving communities that (a) don't
32 necessarily have a face-to-face doctor on the ground at the
33 time or (b) to take the load off some of our face-to-face
34 colleagues so that they can have a breather or they can
35 have a weekend away.
36
37 We do clinically - so I think we cover categories,
38 mostly categories 3 to 5s, ED presentations. We look after
39 inpatients who are admitted under our care. We look after
40 RAC residents at our sites, if they have an acute issue
41 that arises or if they have something that arises when
42 their GP is not around. It's - I feel like it's a very
43 valuable service as an end user.
44
45 As the co-clinical lead, I just provide a bit of -
46 I assist with the medical leadership in the team. So if
47 there are issues that have been identified for improvement,

1 whether by colleagues within the team or colleagues outside
2 of the team, we'll sort of liaise with my colleagues to
3 sort of work through it and system improve. I'm
4 responsible for the rostering and, you know, I've been
5 chairing our meetings recently. Sorry the question put me
6 offhand [sic]. So that's the gist of what the role
7 entails.
8
9 Q. So in terms of the clinicians who are working into the
10 VRGS, is that a salaried position, or are they VMOs working
11 into the VRGS? How does that relationship work?
12 A. So we're paid an hourly rate and so the hourly rate is
13 dependent on what time of day it is. So I think after
14 hours there is an uplift, weekends there is an uplift and
15 public holidays there is an uplift, and we do 10-hour
16 shifts. So, for example, on a usual weekday, 8 to 6pm, for
17 example, if memory serves me right, it's, you know,
18 basically $1700, I think, from memory, for that period, and
19 then - yes, and it's like paid to us not as an ABN or
20 anything, it's just paid via the normal - you know, you get
21 your pay slip and stuff.
22
23 Q. So the VRGS services are delivered through the MPS
24 sites in the emergency departments and - or and more
25 widely; is that right?
26 A. So, like, for example, I can sit here in Baradine, in
27 my little office in Baradine and, you know, virtually
28 I will dial in to say - I will use Coolah, and then there
29 is what we call a WALI, and that's like a big TV screen
30 with a camera on wheels and they wheel it to the patient
31 and then I see them, like the patient in ED or on the ward
32 or in the RAC, you know, like this, yes.
33
34 Q. Is the VRGS service used to provide any cover for GP
35 practices in and around the LHD?
36 A. So as in - you mean, like, as in my little - for
37 example, my Baradine surgery?
38
39 Q. Yes.
40 A. Yes, so no, no, we don't do that.
41
42 Q. And in terms of the - for example, when residents in
43 the aged care facilities are being dealt with, do you have
44 any awareness of what arrangement, if any, exists in
45 relation to MBS money? Is there a 19(2) exemption that
46 you're aware of that enables MPS money to flow through
47 to --

1 A. Some of our sites do have a 19(2) exemption, but I'm
2 going to speak practically. I have - I don't recall ever
3 sort of filling out a 19(2) form for a consultation I've
4 done for an aged care resident whilst I've been on VRGS.
5
6 Q. Is there a particular reason for that in - practical
7 reason for that?
8 A. I don't know the answer to that, I'm sorry. But,
9 like, I just personally haven't done it.
10
11 Q. Can I just take you back to a slightly different
12 issue. Starting with your time at university, could you
13 just walk us through, you know, a reasonably summarised
14 way, the professional journey that you travelled on which
15 led you to practising as a GP VMO in Baradine?
16 A. Yes. I think there is - so I went through a rural
17 clinical school. Bear in mind I grew up in Cabramatta,
18 Fairfield, Sydney, right, so not very rural at all. I went
19 to the Monash rural clinical school, I did my intern and
20 residency at Orange. I did a registrar year in
21 Orange/Bathurst, and then I came out to Baradine in PGY4
22 under the RVTS training program to do my GP registrar
23 training, and I've stayed since.
24
25 Now, I think it might seem that the fact that I went
26 through a rural clinical school and, you know, did my
27 internship and residency in Orange might have sort of led
28 to Baradine, but, you know, there probably is sort of
29 factors that might have contributed through that journey
30 that led me to Baradine, but I'm going to be honest, right,
31 it was one of those sliding doors moments that ended up
32 with me coming to Baradine, and it was simply that I was
33 sitting - I was trying to study for my general surgical
34 sciences exam, was a bit sort of burnt out, a bit stressed,
35 got sick and saw an ad for - I can't even remember, I think
36 it was actually Brewarrina or Bourke at the time, and you
37 know, it was like, "You could earn X amount of dollars if
38 you came out here." And I was like "Wow, that's what
39 a junior consultant makes. I'm going to call up", and they
40 were like "We don't actually have a job but we know these
41 people in Baradine and they are looking." And, you know,
42 that's really how I came out to Baradine. Like if I'm - it
43 probably was a proper sliding doors moment.
44
45 Q. So did that result in you doing RACGP registrar
46 training through the practice in Baradine that you slid
47 through the door into?

1 A. Yes. So I mean, that was the - if it wasn't for that,
2 I wouldn't be in Baradine.
3
4 Q. Did you ultimately take over that practice?
5 A. That's right.
6
7 Q. So the person who you trained with and whose ad you
8 responded to retired; is that right?
9 A. No, so the - previously the Aboriginal health service
10 in Coonamble operated Baradine surgery. They operated the
11 surgery very well. They made their own sort of decision at
12 a particular point in time that it was no longer viable for
13 them - look, I don't know if that's the right word, but
14 they just chose not to continue and I took over. Look,
15 they looked after me very well during that period.
16
17 Q. You joined us in our little visit to Coonamble health
18 service last week and shared with us three points in your
19 career where you tell us you thought about leaving and
20 discussed what it was that led you to stay. It would be
21 great if you could share that with us again now.
22 A. Yeah, sure. So the first part was early on, so
23 probably about three years in to my stay. That was pre
24 VRGS and I was on call 24 hours for category 1s to 5s and,
25 as I said, I was getting woken up, I was very cantankerous
26 and I was just really burnt out. I was ready to throw in
27 the towel. You know, the advent of VRGS has really sort of
28 solved that for me.
29
30 I'm currently in my eighth year in Baradine. You
31 know, for a town like Baradine, eight years is doing all
32 right. And I don't think I could have stayed eight years,
33 even with my wife here, you know, if it wasn't for the fact
34 that I had that reprieve overnight.
35
36 The second point in time was when, like my previous
37 employers decided that they no longer wanted to continue
38 operating Baradine surgery and, you know, I was left with
39 the decision of whether or not to take over the practice or
40 to move on and I think - when I was at Coonamble the other
41 day, the words that I used were that, you know, I think it
42 was a mixture of inertia, guilt about leaving my patients
43 behind, because, you know, you do become - you do develop
44 a great empathy for people that you see day in, day out.
45 And then sort of goodwill to the community, you know, that
46 you wanted to do right by the community. They are all
47 things that really sort of made me want to sort of - like,

1 you know, just kept me around.
2
3 You know, I was a fully fellowed GP then with rural
4 generalist experience. I could have gone to, you know,
5 a very nice touristy town close to the coast or whatever,
6 not to say that Baradine's not nice, Baradine's very
7 lovely. But, you know, I had options. But really it's -
8 I feel like it's those things that sort of kept me around,
9 because financially it wasn't as stable as when I was
10 employed by the AMS. You know, I had all these additional
11 responsibilities of running a business and doing the
12 medical stuff. You know, it was actually the harder path
13 to take. It was a mixture of those things that kept me
14 around.
15
16 I guess the third thing - it's something going into
17 the future, and, like, I would like to stay in Baradine as
18 long as I can, but ultimately, there will probably come
19 a point where I will probably move on, and that's, you
20 know, for the benefit of my children, and that's not to say
21 that Baradine hasn't looked after my family well, they have
22 looked after my family very well. You know, the teachers
23 at the school look after my kids very well. But at the end
24 of the day, you know, you want to give your kids the best
25 options available, and the perception always is that the
26 options are better, or that there are better options or
27 more widely available options in a larger centre.
28
29 I will give you an example, and this is not unique to
30 me but bearing in mind this is unique to everyone in
31 Baradine, right? There is no heated pool, you know,
32 between here and Dubbo, and so during winter, you know, if
33 I wanted to take my kids to swimming lessons, it's a four
34 and a half, five hour round trip to Dubbo every Saturday.
35 Now, I have the means to do that, but there are plenty of
36 people in town who I would hazard a guess don't have the
37 means to do it. But, you know, that's what I mean about
38 options and access.
39
40 Q. So in terms of - those options and access obviously
41 won't be remedied by this, but I just want to ask you
42 a question about the potential desirability of a salaried
43 model for the delivery of the sort of care that you provide
44 into your community, at least up until the point where, for
45 family reasons, you might make a decision to move. You
46 mentioned a little bit earlier that had Baradine become one
47 of the Four Ts, which would have ruined the symmetry of the

1 name, if nothing else, you would have found it a lot easier
2 to stay. What is it about that program that would have
3 made it more desirable for you to stay in Baradine, or
4 perhaps someone like you in another small community, to
5 stay in their community and deliver both primary and acute
6 care through the MPS?
7 A. Can I pick up on a couple of things that you've said.
8 I will start with your question around the Four Ts, right?
9 So if you paid a salary, right, commensurate to the idea
10 that you are on call as well as you are doing your GP
11 consults throughout the day, your 30 consults throughout
12 the day, and it's commensurate to that level of work, then,
13 like, you know, I would have loved that, because I wouldn't
14 have to worry about hiring staff: if there are staffing
15 issues, it's not my problem. I don't have to worry about
16 doing BASs, I don't have to worry about paying bills. You
17 know, just paying bills, not literally in the financial
18 sense but the administrative sense, that all takes time, on
19 top of what we're already doing clinically.
20
21 You don't have to worry about good months, bad months;
22 you don't have to worry about getting sick. You know, when
23 my wife and I had COVID last year we had to close the
24 practice for two weeks, and if you think about the margins
25 and closing for two weeks, that's like basically the
26 quarter's income just gone, obliterated, right?
27
28 So I think that there is a huge role, like, in certain
29 towns, where it is not an attractive market for someone to
30 set up camp individually - set up a business individually -
31 I think there is a role for some of these salaried
32 positions.
33
34 The second point around - that I wanted to pick up on
35 is I actually do think that there is something you can do
36 around addressing the issue of access, like within medicine
37 at least, and that's - it's sort of looking outside the box
38 a bit and not dealing with the access directly but looking
39 at it tangentially. So I have given this a lot of thought,
40 and look, you know, we know that bonded medical places
41 don't work. You know, people do their bonded time and
42 then, you know, they don't necessarily commit, then,
43 afterwards to doing their time in rural communities or, if
44 they do, they don't necessarily come to a place like
45 Baradine, right? They might go to out of Brisbane or out
46 of Sydney, or they might go to a place like Orange or
47 something around there.

1
2 You know, I feel like we should - and this is going to
3 sound - the risk of sounding like this is like nepotism or
4 whatever, right, but I think there should be an opportunity
5 to shift the bond on to parents. Like, you know, I think
6 if you said to, you know, doctors out there, GPs out there,
7 and said "Look, if you came out and worked in the bush for
8 X number of years, we're going to make the path easier for
9 your kids to get into university or easier to getting into
10 medicine", right. I can almost guarantee there would be
11 a big cohort of GPs out there that would come out for five
12 years, because who doesn't want to give their children the
13 best shot or give their children a leg-up. But, you know,
14 I just think it needs a little bit of a different mind set.
15
16 MR MUSTON: Thank you, doctor. I have no further
17 questions for you this morning.
18
19 THE COMMISSIONER: Q. Can I just ask you, doctor, some
20 of the challenges that you have just given evidence about -
21 we don't need to go back through them, but just as an
22 example, one of the things you mentioned just recently was
23 you and your wife both having COVID and having to shut the
24 practice for two weeks and how that, I think you said,
25 obliterated probably the profit you make in that quarter.
26 Are you in any form of formal or even semiformal social
27 group, contact with colleagues of yours that might work in
28 towns that are also small or rural communities that share
29 the same challenges you have just spoken about?
30 A. I haven't spoken to any of my colleagues with the same
31 concerns, no.
32
33 THE COMMISSIONER: Mr Cheney, do you have any questions?
34
35 MR CHENEY: No questions.
36
37 THE COMMISSIONER: Thank you very much for your time,
38 doctor. We're very grateful.
39
40 THE WITNESS: Great, thank you.
41
42 THE COMMISSIONER: You are excused.
43
44 **<THE WITNESS WITHDREW**
45
46 MR MUSTON: We move next to a panel of Helen McFarlane and
47 Dr Warren Kealy-Bateman. Dr Waterhouse will be taking

1 evidence from those witnesses.
2
3 DR WATERHOUSE: Ms McFarlane, if I could start with you,
4 could you please state your full name for the record?
5
6 THE COMMISSIONER: We might have to have the witnesses
7 sworn.
8
9 **<HELEN McFARLANE, affirmed: [10.19am]**
10
11 **<WARREN KEALY-BATEMAN, affirmed:**
12
13 **<EXAMINATION BY DR WATERHOUSE:**
14
15 DR WATERHOUSE: So, Ms McFarlane, could you please state
16 your full name for the record?
17
18 MS McFARLANE: Helen Maree McFarlane.
19
20 DR WATERHOUSE: And Dr Kealy-Bateman?
21
22 DR KEALY-BATEMAN: Dr Warren Michael Kealy-Bateman.
23
24 DR WATERHOUSE: You both have a copy I think of your
25 outlines of evidence. If I could just start with you,
26 Ms McFarlane, have you had a chance to review that before
27 today?
28
29 MS McFARLANE: Yes, I have.
30
31 DR WATERHOUSE: Is it, to the best of your knowledge, true
32 and correct in the context?
33
34 MS McFARLANE: Yes, it is.
35
36 DR WATERHOUSE: Dr Kealy-Bateman, can you - you have an
37 outline there. Have you had a chance to review that.
38
39 DR KEALY-BATEMAN: Yes, I have.
40
41 DR WATERHOUSE: Is the content true and correct?
42
43 DR KEALY-BATEMAN: Yes, it is.
44
45 DR WATERHOUSE: Commissioner, we will be including those
46 in the bulk tender bundle and I will just have them pulled
47 up on screen because I may go to both of them, they are

1 [MOH.9999.1268.0001] and [MOH.9999.1270.0001].
2
3 If we just start with yours, Ms McFarlane, can you
4 please outline your current position?
5
6 MS McFARLANE: Yes, so I'm currently the director of
7 Mental Health Drug and Alcohol for Western New South Wales
8 LHD.
9
10 DR WATERHOUSE: How long have you been in that role?
11
12 MS McFARLANE: I was formally appointed in February of
13 this year but I've worked in mental health drug and alcohol
14 for Western for around 25 years now.
15
16 DR WATERHOUSE: Do you have a clinical background?
17
18 MS McFARLANE: Yes, I'm a nurse by trade.
19
20 DR WATERHOUSE: Mental health trained nurse.
21
22 MS McFARLANE: I've always worked in mental health as
23 a registered nurse.
24
25 DR WATERHOUSE: What does your role involve?
26
27 MS McFARLANE: I oversee service delivery of all mental
28 health, drug and alcohol across Western NSW, so that
29 involves inpatient services and community mental health
30 drug and alcohol services. So any programs that are
31 delivered down from the state and any Commonwealth
32 bilateral programs that occur within our district, I'm
33 responsible for, plus a workforce of around 800 FTE.
34
35 DR WATERHOUSE: Dr Kealy-Bateman, can you outline your
36 position, please?
37
38 DR KEALY-BATEMAN: I'm the local clinical director of
39 Mental Health Drug and Alcohol for the Northern Sector of
40 Western New South Wales Local Health District. In my role,
41 I see patients as a consulting psychiatrist. I also
42 provide leadership for this region. We have about 200
43 employees in this part of the region. That also includes
44 quite considerable support for the medical, nursing, allied
45 health staff, as well as our peer workers and Aboriginal
46 health staff.
47

1 DR WATERHOUSE: I understand that you - you are
2 responsible for the medical, nursing and allied health FTE
3 within that region?
4
5 DR KEALY-BATEMAN: I support the operations hub manager in
6 that role as well.
7
8 DR WATERHOUSE: I understand you also have some public
9 health qualifications; is that right?
10
11 DR KEALY-BATEMAN: Yes, I have public health training from
12 New York University.
13
14 DR WATERHOUSE: Is there an interface between your two
15 roles? Do you work together on some things? Are there
16 some aspects that are directly one or the other
17 responsibility? Maybe, Ms McFarlane, if you start?
18
19 MS McFARLANE: Yes, so I sit - the executive sit with me
20 and part of that executive is - one of those positions is
21 the clinical director for mental health drug and alcohol,
22 who oversees all the psychiatry team and also oversees the
23 services that are provided. So we have three hubs, which
24 are our main sites, which are Dubbo, Bathurst and Orange,
25 and in those hubs there are clinical directors that are
26 appointed to service delivery in those towns. So we
27 regularly have get-togethers and meetings to actually talk
28 through issues and service delivery areas that we need to
29 work on.
30
31 DR WATERHOUSE: Dr Kealy-Bateman, did you want to add to
32 that at all?
33
34 DR KEALY-BATEMAN: I report to the overall clinical
35 director, Dr Scott Clark, who oversees all of Western
36 New South Wales.
37
38 DR WATERHOUSE: So if we go to paragraph 4 of your
39 outline, Ms McFarlane, you refer there to working with
40 partners to embed new ways of delivering care. So, first
41 of all, who are the partners that you have in mind in
42 relation to that work?
43
44 MS McFARLANE: So outside of our mental health service,
45 our partners are internal, so within the LHD, so integrated
46 care, other service delivery partners that are in that
47 team. But external to that is our NGO providers and also

1 the PHN. So because there is so many funding bodies that
2 sort of govern what programs are delivered across the
3 district, it's really important for us to engage not just
4 internally but with those other service providers so we can
5 try to map what's happening across the district.
6
7 DR WATERHOUSE: How many NGOs do you have to deal with?
8
9 MS McFARLANE: Oh, I couldn't give you an accurate --
10
11 DR WATERHOUSE: An estimate perhaps of the sort of number
12 we're talking.
13
14 MS McFARLANE: So anywhere - well, the main ones, there's
15 probably about six really main ones which are across the
16 state, not just here, and then there could be anywhere
17 upwards of 20 or 30 smaller ones that are across the
18 district. So it's quite a large number. We work with the
19 PHN to try and map who those NGO providers are within our
20 service and we've also got state funded projects that the
21 state give funding to particular NGOs that - part of that
22 KPI is we are part of that governance process of actually
23 delivering those services. That's kind of how we map it.
24 There is no actual map on the ground. It really is just
25 about who we can reach out to and who reaches out to us for
26 support.
27
28 DR WATERHOUSE: Do they tend to be involved in both mental
29 health and drug and alcohol, or do they sit in either of
30 those areas?
31
32 MS McFARLANE: The majority of them are involved in mental
33 health and there is a growing number, I suppose, that are
34 engaging in drug and alcohol services as we grow those drug
35 and alcohol services.
36
37 DR WATERHOUSE: How do you work in with those
38 non-government organisations?
39
40 MS McFARLANE: So at my level, so at that executive level,
41 we have key meetings with the PHN in particular, so we have
42 like an overarching steering committee. There's been, you
43 know, changes within our local PHN, so that's been
44 difficult in recent times, but we're re-engaging now that
45 their internal structure is getting more settled. So they
46 are about coming together and actually looking at service
47 delivery across that primary care space as well as the

1 acute space that we sit in. So PHN look after up to that
2 non-acute, I would say, and then ours is more about the
3 acute hospital and that community - acute community mental
4 health area. So that's at that executive level.
5
6 Then I have team members that sit at committee
7 meetings across the district and that's at local
8 stakeholder engagement, so what's happening in that town
9 and who those NGO providers are, so we come together.
10
11 DR WATERHOUSE: With the PHN, you said that there have
12 been some changes. Was there a period when it wasn't
13 perhaps working as well? How would you describe the
14 relationship over time?
15
16 MS McFARLANE: I think we've always strived to have a good
17 relationship, but because of their internal changes, which
18 have happened a lot in recent times, it's been really hard
19 to actually get traction with the same person, so you will
20 have somebody for a period of time and then they go and
21 then there is a new person. So we know how important it is
22 to work together because we are in the same space, and
23 that's my hope, is that we continue those relationships as
24 they now have somebody in place that we can work with.
25
26 DR WATERHOUSE: Do you have other ways of reaching out to
27 general practitioners apart from the PHN?
28
29 MS McFARLANE: So we have our own engagement,
30 communication processes with GPs as well, so a lot of our
31 services that we offer have actual direct links with GPs.
32 So I've mentioned our virtual community mental health
33 service in particular has strong relationships with GPs,
34 because they can refer in. GPs can also refer in to our
35 hospital as well, so there is always that local connection,
36 but, you know, that larger connection is through the PHN,
37 yes.
38
39 DR WATERHOUSE: Dr Kealy-Bateman, in paragraph 4 of your
40 statement you refer to strategic learnings arising from
41 working in partnership with, and you've listed there:
42 patients, loved ones, staff, other health care providers
43 and also the broader community. I would be interested to
44 hear how you work in partnership with those different
45 groups or individuals.
46
47 DR KEALY-BATEMAN: So some of the deficits we noticed

1 a few years ago around the time of COVID were that in the
2 previous years when we had some staff shortages, we were
3 really poor at completing discharge summaries, so I can
4 give that as a brief example, and we had staff sick and
5 unavailable, in terms of the junior medical officers, so
6 interns, residents, registrars, who were people early in
7 their training in psychiatry. So they are in the inpatient
8 space.
9
10 So we had a focus in early 2020 of really making sure
11 that every person leaving the inpatient space in the Dubbo
12 hospital, who were admitted in mental health, had
13 a discharge summary completed every time.
14
15 When we looked at the broader Western New South Wales
16 Local Health District, we noticed that not everyone got
17 a discharge summary when they were leaving our health
18 service back in that time, so that's historic now, and the
19 rate of discharge completion was less than 50 per cent.
20 That was because sometimes --
21
22 DR WATERHOUSE: Sorry, less than?
23
24 DR KEALY-BATEMAN: Less than 50 per cent. That was
25 sometimes because in our multi-purpose services, so that's
26 the smaller sort of hospital sites, to define that, that's
27 the sort of smaller sites where we have visiting medical
28 officer GPs, for example, working in those sites,
29 discharging to themselves, following up patients, so you
30 know, they're trying to be agile and not necessarily
31 writing things to themselves, so that's a duplication of
32 time for them. But they weren't completing them. But, for
33 us, this was really important to communicate to people, so
34 we really wanted to try to communicate to people, so we did
35 that. So we actually increased it to 100 per cent and
36 we've been able to maintain that since in the mental health
37 space.
38
39 DR WATERHOUSE: I was going to come to that later, but
40 I might bring it up now. I understand you published an
41 article about that, if we could just maybe pull that up.
42 It's [MOH.9999.1272. --
43
44 DR KEALY-BATEMAN: I was going to add to that, and that's
45 to say that the other part of that puzzle was that we
46 needed to learn to always work with families in that work
47 in the inpatient space, too.

1
2 DR WATERHOUSE: Can we just go to this first?
3
4 DR KEALY-BATEMAN: Yes, sure.
5
6 DR WATERHOUSE: If we just look at the second page of
7 that, if we could just scroll down, there is a "What is
8 already known on this subject", at the top right, there,
9 and "What this study adds". Can you maybe just expand on
10 what you did in terms of the co-design of the discharge
11 plan?
12
13 DR KEALY-BATEMAN: Yes. So what we did in terms of the
14 co-design of the discharge plan is we noticed that in terms
15 of our electronic medical records, things were often not
16 populated right, so we noticed that the GP was often wrong,
17 so people would circle in, and it was accepted as fact,
18 that whoever was listed on the electronic medical record
19 was correct. Well, that was clearly not correct. If we
20 asked people, that had often changed. Their patient
21 contact person was often not correct and faithful to what
22 that person actually wanted as their contact person, and it
23 didn't always need to be a family member; it sometimes was
24 the person who was their closest friend.
25
26 The other thing that we wanted to understand was if
27 the person identified as Aboriginal, what Aboriginal nation
28 they identified with. They didn't always know what their
29 Aboriginal nation was. Aboriginal people told us that that
30 was really important to them, and then it made the
31 experience much more the experience needed for them.
32
33 We also wanted to include their next of kin in the
34 discussion. We also wanted to document that in the
35 discharge summary as well so that the GP could see that and
36 know who was important to them.
37
38 So we kind of tried to bundle up all of these things
39 to kind of make the discharge summary a living, important
40 document, and it made it more likely to become true as
41 a health care plan that the person was invested in and
42 interested in in the future.
43
44 In continuing this work forward, we now audit all of
45 these things and check every discharge summary with our
46 medical students as well, with the doctors who do them, and
47 make sure that they are all done, but we have discussions

1 around this as an ongoing basis as a value that this is
2 what you would also want if your family was admitted in our
3 service.
4
5 I know we're a very small site and not everyone does
6 this, but this is a professional value that is important
7 for us as a health service. So we've managed to change our
8 behaviour but, most importantly, we've managed to work with
9 people the way we would like to be worked with ourselves.
10
11 DR WATERHOUSE: Do you find that with the changeover of
12 junior medical staff, any of that is lost, or have you been
13 able to maintain that?
14
15 DR KEALY-BATEMAN: We've been able to maintain it because
16 we do the audits. So we have 500 admissions a year to
17 Dubbo hospital in mental health, and because when you do an
18 audit you get a list of patients, and you're doing the
19 audit, say, every three months, you are only looking at
20 120 discharges. So it actually doesn't take long to go
21 through them. And we actually look at some of the detail,
22 we pull up a few and we look at the detail and we praise
23 what's good and we also look at, "Well, we could improve
24 this", or "We could improve that", or "I'd do this a little
25 bit differently because, and that would make it stronger
26 and better for us as a service." We use that as a learning
27 opportunity.
28
29 So the whole momentum of the project keeps going. And
30 we also have some premortem thinking in that, too.
31 Premortem thinking is where you think: well, what if the
32 worst possible thing happens to this person in the future;
33 what would we like to find in this document to make it the
34 best possible document for the patient, their family, for
35 you as a working professional and, also, for the service.
36
37 So we don't want the document to be lengthy and long
38 and horrible. We want it to be easy for the GP to read as
39 well. So we focus on discussions around that, and that
40 keeps the project going.
41
42 DR WATERHOUSE: When you say it goes to the GP, what will
43 happen if they've got the wrong GP on the record?
44
45 DR KEALY-BATEMAN: Well, it won't go to the right GP. So
46 that's why it's really important to ask the patient.
47 Patients sometimes don't know their GP, so for a lot of

1 patients, they do have the My Health Record, so we can
2 actually just click through and find out the last GP
3 they've seen. Patients mangle GP names. I've got a long
4 name and patients mangle my name, too, so I'm accustomed to
5 that. So we can actually do some fact checking and data
6 checking to make sure we get that faithful. And GPs
7 change. So at least we can try and identify the right
8 practice.
9
10 But this is where involving families is really
11 important, because families know more about health care
12 than we realise, and when patients are going back to
13 a place 280 kilometres from where we sit today - for
14 example, we're sitting in Dubbo and a family might be in
15 Walgett - we need to ask the family, they will often know
16 stuff that we don't know so they can help us populate these
17 documents so they are as authentic and right as possible.
18
19 DR WATERHOUSE: Are the patients themselves given a copy
20 of the plan?
21
22 DR KEALY-BATEMAN: Yes, we try to. We also encourage them
23 to look at their myGov app or get it on the phone if they
24 have a phone - they don't always have a phone. We
25 encourage them to try and use the My Health Record, if
26 they're interested in doing so, so that they can access the
27 document. Sometimes mental health documents for our
28 patients are also helpful in a legal sense, if they are
29 before the court for anything, for example, in showing that
30 they have a mental health history. So there's lots of
31 reasons why we encourage them to use these documents for
32 their own good. It also helps them to get their
33 medications right and not make any errors, and that
34 increases their health outcomes, the goodness of their
35 health outcomes.
36
37 DR WATERHOUSE: Is this a sort of quality improvement
38 strategy that you think could be rolled out to other mental
39 health units in the state, not just rural but also
40 potentially metro?
41
42 DR KEALY-BATEMAN: I think so, because it's of value. So
43 there is a - you know, in benchmarking how much something
44 is done, we have lines, and I think the line should be
45 every person, every time, not a line of 80 per cent or
46 90 per cent. I mean, I always think if it was my aunty or
47 my uncle or my cousin, what would I want done, and I always

1 think in terms of premortem thinking, what if there was the
2 worst possible health outcome for this person, what would
3 I want to find in that health trajectory and journey for
4 that person? I would want to find, you know, at least
5 a pedestrian medical document that had the basic
6 requirements, and that included an attempt to work with
7 family, the right medications, some sort of narrative and
8 story about who that person was. And that's not just
9 a discharge summary, that's all of our health record.
10 That's all of our health record everywhere.
11
12 And it can sometimes be written in a lean way, when
13 we're short of resources, but we need to encourage our
14 healthcare workers to do that, and it doesn't matter which
15 sort of healthcare worker they are. And we can be informed
16 by our consumers and their families about also what to
17 write in that record, what's acceptable to them. And in
18 asking them to read these documents, we actually get
19 feedback about what's right for those documents. We get
20 that recalibration of what's acceptable to them. Because
21 they sometimes come back and say, "I wasn't sure what you
22 wrote there", and sometimes I might have to explain, "Well,
23 that's a technical thing that I've written there, and
24 that's why I've written it."
25
26 But sometimes, it's not; it's just not acceptable, and
27 so we get that learning both ways.
28
29 DR WATERHOUSE: Before we move away from this, is there
30 any other comment you want to make about this particular
31 quality initiative that you have done?
32
33 DR KEALY-BATEMAN: Not about that quality issue, no.
34
35 DR WATERHOUSE: Ms McFarlane, is this something that you
36 have looked to role out to other hubs within the district?
37
38 MS McFARLANE: Yes, absolutely. So we've got
39 Dr Kealy-Bateman and he came over and did a presentation in
40 Orange. That's our biggest cohort of inpatient units. We
41 don't sit at 100 per cent. We vary between 85 and 90,
42 which is better than what it used to be. But I think
43 something like this initiative is really, really important
44 and it was about actually designing the discharge summary
45 with the consumer at the centre of it and their carers
46 around it, supporting them, or their support networks,
47 because at the end of the day, once they leave our

1 facilities, we're sending them back to the community where
2 they exist and it's really important for that community to
3 have an understanding of what happened in the hospital
4 journey and what they can do to support them at home. So
5 I think it's really - it's an initiative that can be rolled
6 out. There's no reason why it can't, and it's scalable.
7 It doesn't have to be just rural and regional, it could
8 easily be in the metro.
9
10 THE COMMISSIONER: I take it with these discharge summaries
11 there is like a pro forma that is then populated by the
12 information that the clinicians put in, including the
13 information given by patients and next of kin; is that
14 right?
15
16 MS McFARLANE: Yes, correct.
17
18 THE COMMISSIONER: I don't know that we've got one of
19 those in the evidence so it might be useful just to have
20 the pro forma put in the evidence.
21
22 DR WATERHOUSE: We can do that, Commissioner.
23
24 Just finishing off on that, what was the reception
25 from the psychiatrists and other mental health workers in
26 Orange where the presentation was given?
27
28 MS McFARLANE: Again, different facilities, and as Warren
29 has stated, it is a small population, as in hospital
30 population, inpatient beds, with Dubbo, and Orange has
31 a much bigger population, higher overturn, but it is just
32 changing the mind set. If we can get it right now, then it
33 actually supports that if this person unfortunately has to
34 come back, for whatever reason they escalate and they need
35 readmission, it actually just helps the whole process and
36 it makes it easier the next time around. So I don't think
37 any of them were opposed to it; it's just now they've got
38 to put the work in to actually make it happen.
39
40 We also have a higher turnover of medical officers at
41 Orange, just because it is so large, so actually keeping
42 the traction, like with Warren's project in Dubbo, he can
43 oversee it, whereas we have to do that in Orange
44 differently. So there is going to be some, you know,
45 differences to how it is in Dubbo, but the actual basis of
46 it I think is very doable, and nobody was opposed to it.
47

1 DR WATERHOUSE: Thank you. We might go back to the
2 outlines now. If I can just go to yours, Ms McFarlane, you
3 talk there about, in paragraph 4(a), the fact that there
4 are 188 inpatient beds across the local health district.
5
6 MS McFARLANE: Yes.
7
8 DR WATERHOUSE: In your view, is this enough for the
9 population?
10
11 MS McFARLANE: I don't think you could ever say that there
12 is going to be enough beds. I'm not saying that we maybe
13 need more beds. I mean, I think if you put more beds, you
14 will fill more beds. I think where we're at is we have
15 a very healthy number of beds in our Orange population; we
16 probably need to look at the Dubbo and region population,
17 because it has increased in its access to mental health and
18 its needs. But I think the focus really needs to be on the
19 community mental health services and actually investing
20 more in those resources.
21
22 DR WATERHOUSE: We will come back to that, if that's okay.
23 What about just in terms of the breakdown of beds that you
24 have there. Is that the right sort of - within the beds
25 that you have, is that the right sort of balance of bed
26 types and where they are located?
27
28 MS McFARLANE: Yes, I think we're actually really very,
29 very privileged. We cover the entire life spectrum. So
30 it's very rare across any other LHD that you would get the
31 number of beds we've got for the entire life spectrum. So
32 we've got a cohort of child and adolescent beds. We didn't
33 have them 10 years ago, so that's only a new introduction
34 for us. And then we go right up to the old-age spectrum,
35 plus we have forensics.
36
37 So I think for a rural/regional area, we have quite
38 a sufficient number of beds. A lot of those beds, though,
39 are statewide, which means they are not catering just for
40 our LHD, they are catering for the entire state. So half
41 of those beds are actually statewide beds. So I think
42 going into future focus, we need to look at more access for
43 local people to gain access to beds. So the acute beds,
44 that's fine. They are - whoever needs them can get them.
45 But a lot of the rehabs are statewide beds and I think they
46 are the ones we probably need to look at going into the
47 future to make it more locally based rather than statewide

1 based.
2
3 DR WATERHOUSE: Can you just expand on what you mean by
4 a "statewide bed"?
5
6 MS McFARLANE: A "statewide bed" means that a person can
7 be referred to that bed from anywhere across the state. So
8 there is networks, and we have networks for forensic beds,
9 we have networks for our medium secure rehabilitation beds,
10 of which we have 52 of those, so that's male, female, and
11 a medium secure civil unit. So all of those are networked,
12 which means there is a group or a committee that sit at
13 state level and they look at referrals across the state for
14 particular individuals and where the best bed is available
15 is where they come to. So it could be from anywhere across
16 the state. That's inclusive of our IDAC unit which is our
17 involuntary drug and alcohol unit.
18
19 DR WATERHOUSE: At any given time, do you have an idea of
20 what proportion of those beds that are statewide beds will
21 be occupied by people who are from outside the local health
22 district?
23
24 MS McFARLANE: Majority. So at least probably 70 to
25 80 per cent of the occupancy will be outside of the
26 district.
27
28 DR WATERHOUSE: Are they tending to be from other rural
29 areas, or are they actually being sent from metropolitan
30 areas out to Orange or --
31
32 MS McFARLANE: No, they come from metro as well as rural.
33 Probably the most recent service is our medium secure civil
34 unit, and Campbelltown opened one just this year, so it
35 really is the clinical team come together and they review
36 everybody that's on the wait list, and it's where the bed
37 is available at the time. So Campbelltown are at a staged
38 opening, so they haven't opened all their beds, so if they
39 are full, then - and we have beds in Orange, then they come
40 to Orange. So that's pretty much how it works.
41
42 DR WATERHOUSE: Dr Kealy-Bateman, you refer in
43 paragraph 5(c) to your view is that there are insufficient
44 beds, and you list there that there are 20 beds for Dubbo.
45
46 DR KEALY-BATEMAN: Mmm-hmm.
47

1 DR WATERHOUSE: And that's for a population of 140,000.
2
3 DR KEALY-BATEMAN: Yes.
4
5 DR WATERHOUSE: Can you just outline for me, do you have
6 a sense of how that compares to other places where there is
7 a similar catchment population?
8
9 DR KEALY-BATEMAN: I can't without taking that on notice,
10 because I haven't looked at the figures elsewhere, but I do
11 know from the point of view that we've made our unit, as
12 I outline in that paragraph, as operationally efficient as
13 possible. If, for example - and I will use the bold
14 phrasing - if we drove patients out of our units any
15 faster, we would make them unsafe. We know in terms of the
16 28-day readmission rates, we're very, very safe in terms of
17 the unit; we know with our outcomes we're safe in terms of
18 the unit, but we can't make it any more operationally
19 efficient. We know we've got the balance right. We work
20 closely with people in terms of discharge planning and we
21 only have 10 gazetted beds.
22
23 We also know that a lot of roads lead towards Dubbo
24 and we have a very high rate of people staying more than
25 24 hours in the emergency department. We don't have enough
26 gazetted beds, and those are the beds - we only have 10
27 gazetted beds, so those are the beds where people come that
28 need to be under the Mental Health Act. So 10 of our beds
29 in Dubbo are subacute beds and all of those bedrooms have
30 doors that open to the outside world. So, for example, if
31 someone was at risk because they might wander off and have
32 misadventure, they can't be in those beds. So we've really
33 only got 10 beds for people who are at significant risk,
34 for a very large population.
35
36 So if a lot of people need them at once, they then
37 need to go down the road to Orange and that's really
38 dislocating and it also puts a great burden on our
39 transport services. So we don't quite have enough.
40
41 In terms of future planning, I understand that we
42 are - we have got planning for a unit for 18 beds in the
43 future, so there's recognition from the ministry that we
44 haven't quite got it right, and in terms of local
45 government projections, Dubbo is expected to grow by about
46 22.5 to 25 thousand people in the next 20 years. So we do
47 need to get the balance right in this region. There is

1 a bit of imbalance.
2
3 DR WATERHOUSE: So those 18 beds would be in addition to
4 the 20 that you have currently?
5
6 DR KEALY-BATEMAN: No, it would rise from 10 gazetted beds
7 to 18 gazetted beds.
8
9 DR WATERHOUSE: So a total of 28 beds.
10
11 DR KEALY-BATEMAN: Yes.
12
13 DR WATERHOUSE: When you talk about gazetted beds and
14 people being in them that are under the Mental Health Act,
15 by that do you mean that these are involuntary patients?
16
17 DR KEALY-BATEMAN: No. So someone can be in one of the
18 gazetted beds and voluntarily be in a mental health unit
19 and agree not to have leave because - if they were unsafe,
20 et cetera, or they might be on leave with their family, or
21 whatever. But sometimes when somebody, for example, who
22 might be very suicidal, needs the four walls around them to
23 keep them safe, that might be a reason they are in the
24 hospital.
25
26 DR WATERHOUSE: You might have a mixture of involuntary
27 and voluntary patients within those beds.
28
29 DR KEALY-BATEMAN: And we sometimes do but, for example,
30 yesterday I went in, we had 10 patients and I was actually
31 a little bit shocked because it doesn't always happen, but
32 all patients were under the Mental Health Act. That's
33 relatively rare. It's usually about 70 per cent under the
34 Mental Health Act.
35
36 DR WATERHOUSE: With the subacute beds that you mention,
37 are they people who may have started in one of the gazetted
38 beds and progressed to be --
39
40 DR KEALY-BATEMAN: That's correct.
41
42 DR WATERHOUSE: Would all of them fit into that category,
43 or would some be directly admitted there?
44
45 DR KEALY-BATEMAN: No, we have direct admissions also to
46 the sub-acute unit. So that may be someone who needs
47 mental health care and is deemed perfectly safe for that

1 unit. We had an older gentleman, for example, who was
2 admitted there recently, and he is having all his care
3 there.
4
5 DR WATERHOUSE: We might scroll up to paragraph 5(b) of
6 your outline. So this is where you refer to the
7 overrepresentation of First Nations people. You note there
8 that they comprise - people identifying as Aboriginal
9 comprise 40 per cent of your mental health admissions each
10 year, and that there is poor attendance of those people
11 with community health.
12
13 DR KEALY-BATEMAN: Yes.
14
15 DR WATERHOUSE: In primary health care, sorry. Why do you
16 think that is? Can you just expand on that for us?
17
18 DR KEALY-BATEMAN: Yes, sure. The background population
19 in the local government area for Dubbo - and that comprises
20 the bulk of the population that we serve, is 20 per cent.
21 So just to contrast that, 40 per cent is really important.
22
23 A lot of people don't recognise the difficulty that
24 colonisation has posed for Aboriginal people, and when
25 I talk about Aboriginal people, I'm talking about the
26 cohort. I'm not talking about individual Aboriginal
27 people, some of whom have managed to do quite well despite
28 the legacy of colonisation. I want to make that really,
29 really clear. Aboriginal people have twice the rate of
30 suicide per hundred thousand people; lower incomes overall
31 as a cohort; greater health morbidity overall in terms of
32 general health outcomes with their physical health; and
33 a much higher rate of incarceration - 2,500 people per
34 100,000, compared to about 160 per 100,000 for
35 non-Aboriginal people. That's heartbreaking.
36
37 I have been the psychiatrist for Wellington, the town
38 of Wellington, the only adult psychiatrist there, working
39 in private health, there are no private psychiatrists
40 there, of course, for 15 years, and it's heartbreaking.
41 Half of my patients don't turn up to my clinics even though
42 most of them adore me. I mean, I've been made a godfather
43 by one of my staff down there to her son, and she's
44 Aboriginal.
45
46 People don't feel a good cultural fit for our health
47 services, and we see the evidence in people coming to our

1 emergency departments, whether it's in a big hospital or
2 MPS, and not waiting. They are in a desperate situation
3 and they don't wait.
4
5 DR WATERHOUSE: Just before we go on to that - I do want
6 to explore that a bit more and I am not in any way
7 diminishing what you have said about colonisation - could
8 you draw the link for us in terms of why is it that the
9 effects of colonisation mean that people don't engage with
10 primary health care or community health services when they
11 may be at an earlier stage of their mental health
12 condition?
13
14 DR KEALY-BATEMAN: Because people don't find them safe.
15 I mean, just near here, I work in a convent that was built
16 in 1880, and it is a building that the health service
17 leases, and I think I've had 30 or 40 Aboriginal people
18 tell me that that's not an appropriate building for us to
19 be using. They don't find that building a safe building
20 because of what it represents to them, and it's bounded by
21 a big fence, and there's lovely Aboriginal authors who have
22 written about how wrong it is that we fence everything in
23 the way that we do.
24
25 A lot of what we do that we might take for granted as
26 a non-Aboriginal person is really offensive in a way that
27 we don't even conceptualise and understand. It's in having
28 those conversations that you begin to understand things
29 that you would not have otherwise understood over a long
30 period of time. They are just two examples.
31
32 DR WATERHOUSE: Taking that example of 30 or 40 people
33 saying to you that this environment where you're meeting
34 them is not an appropriate environment from their
35 perspective, what can you do with that information? Do you
36 speak to Ms McFarlane, do you take it somewhere else within
37 the district? How do you try to effect change that will
38 support those patients?
39
40 DR KEALY-BATEMAN: So that's a really good question, and
41 that's a question that we've been running with for a long
42 time in thinking about what to do. One of the strategies
43 we've used over the years is we've engaged very much with
44 Charles Sturt University and we've had Aboriginal trainees
45 engaged in our service and, wherever we can, we try and
46 employ them thereafter. And they've been a really good
47 link to working with Aboriginal people and hearing the

1 individual stories and narratives so that you actually pick
2 up - just like the discharge summaries, you pick up one at
3 a time what are the issues, how do we address them and how
4 do we change. So a lot of conversations at that convent
5 that I'm talking about are held outside the building.
6 We're actually on a project to build a yarning circle there
7 now. We're working on appropriate signage. We got a name
8 for that building and that space from the local lands
9 council. It's called "Nunyara", which means well again,
10 but it's actually addressing each person's challenge or
11 difficulty in the way that they conceptualise it, one at
12 a time, and breaking it down and you make each person's
13 health journey work for them. Because it is not one size
14 fits all. It is never, ever, ever one size fits all. And
15 you do that through your Aboriginal health staff.
16
17 And I've a got to say, from a resources perspective,
18 working with Aboriginal health staff is very, very, very
19 effective. Someone like me, as a specialist doctor who has
20 had a lot of training, is a very, very expensive resource.
21 You can get a lot of Aboriginal health staff compared to
22 having one of me. And they are much more effective at
23 promoting change. And I think that's really worth
24 reflecting on.
25
26 DR WATERHOUSE: You started to go into the detail of
27 people presenting to the ED and how they find that from
28 a cultural perspective. And in your outline, you refer to
29 the term "cultural" - whether it is "culturally safe". Can
30 you just define for us what you mean by "cultural safety"?
31
32 DR KEALY-BATEMAN: For me - I mean, there are lots of
33 different academic definitions but, for me, a culturally
34 safe space is where someone feels welcome, they are able to
35 navigate it, and they know that they are on a journey where
36 they are going to find the outcome that they are seeking.
37
38 I've spoken before about people coming to us and
39 coming to a place they don't really want to go at a time
40 they are really desperate and then not finding the outcome
41 they need. So they might have been using substances, and
42 people often use substances to kind of self-medicate
43 difficulties they've had earlier in their life to navigate
44 violence around them, to navigate sadness, et cetera, and
45 then they might come to us because they are in a terrible
46 state because the substances have made them feel so awful.
47 Then they come to us and they don't really want to come to

1 us, and then they can't navigate our system and they are
2 actually asking for help, and we have the help that they
3 probably need. And then they leave our emergency
4 departments. It's terrible.
5
6 Often when we've got people who are friendly to First
7 Nations people or are First Nations people themselves in
8 our departments, they are often able to hold and contain
9 them and navigate those spaces successfully. "Mate, what
10 do you want to tell me?" "How can we help you?" "What do
11 you need?" "I've seen this work before. This has worked
12 for this fella", like, you know, you have these
13 conversations that are really precious. And sometimes,
14 they can be lifesaving, because when people leave our
15 departments, they don't get the care they need, and we talk
16 about Towards Zero Suicide. Well, we need to kind of back
17 that up with action.
18
19 I would certainly like to see more people with
20 Aboriginal bachelors degrees, who are Aboriginal, working
21 in places like here, where we have very high numbers of
22 Aboriginal health care consumers in our community.
23
24 DR WATERHOUSE: If I can just go to you, Ms McFarlane, is
25 the idea of having Aboriginal health workers or Aboriginal
26 staff working in EDs something that you are trying to
27 implement across the district?
28
29 MS McFARLANE: Yes. Like Warren just talked to the
30 Djirruwang program, which is the Aboriginal training
31 program that we're invested in, so that's through Charles
32 Sturt University, it's been around for a significant number
33 of years, and our LHD in particular has been very
34 successful in retaining those trainees and converting them
35 to mental health clinicians.
36
37 That is what we want to do. We want to keep growing
38 that. We can take upwards of six over that three-year
39 period, because it goes for three years, and they come out
40 with a degree at the end of that. And I think that's the
41 way that we can invest into our communities.
42
43 The other thing that we're trying to achieve is not so
44 much the mental health clinician workforce but a peer
45 workforce, and utilising peer navigators, which I think
46 Warren alluded to, navigating our system is really, really
47 complicated, and for First Nations people, they either get

1 it when they walk through the door, or they don't get it
2 and they walk away. And if we can get them to walk through
3 the door, that is the best thing that we can possibly
4 achieve, and if we can do that at a community level, then
5 that's even better. So having peer navigators - we have
6 piloted it with the Mental Health Commission and we piloted
7 it in Coonabarabran and Gilgandra, and - but we only had
8 funding for six months. It was really, really successful.
9 Those people were in the community, they were invested in
10 their community, they sat within community health centres
11 or Aboriginal Medical Services, and people knew how to
12 connect with them and they just literally helped them
13 navigate the system. So if they needed mental health, if
14 they needed an NGO, if they needed a GP, if they needed
15 anything, those navigators were there to support them.
16
17 And we built a support network for the navigators, so
18 we have a peer navigator community of practice, so to
19 speak, where they can all come together and actually work
20 through issues that they are working with. It was so
21 successful, and the money did stop, that we actually
22 invested in it internally with our own mental health
23 budget, and so it continues.
24
25 The one at Gilgandra, I believe, or Coonabarabran,
26 moved to Bourke, so we were able to roll it out into
27 Bourke. So that's what we're trying to achieve now in this
28 next financial year. We got some more funding, so we've
29 got at least 7 FTE, I believe, that we are able to invest
30 into the peer navigator workforce and what we want to do is
31 make those identified positions especially in the remote
32 communities, because if we can get them in their community
33 and working within their community, then I think that's the
34 avenue to opening the door to that primary care setting.
35 So integrating, building capacity within community, I
36 think, is the most important part.
37
38 DR WATERHOUSE: So those are people that are in the
39 community and they are peers, so they have had either a
40 mental health or drug and alcohol problems themselves, or
41 both?
42
43 MS McFARLANE: Yes.
44
45 DR WATERHOUSE: What about in the emergency department, so
46 someone is presenting in a crisis, perhaps, are there
47 people there in most of your emergency departments who are

1 able to facilitate their journey?
2
3 MS McFARLANE: Again, it was only last year, with the
4 winter strategy, that we actually looked at and we worked
5 with - it had actually started with integrated care within
6 our LHD with "The Emergency to Community" program that they
7 were delivering at a statewide. In Western New South Wales
8 in particular, the most amount of people coming through the
9 EDs that are revolving, so they constantly are
10 re-presenting, are mental health consumers, so integrated
11 care and mental health partnered to actually look at that
12 program to see how we could make a better effect. So we
13 invested in putting peer workers into EDs in the main hubs,
14 so the Bathurst, Dubbo and Orange EDs have a peer worker.
15 It was successful. It's very successful in Dubbo. So
16 we're trying to continue that process, so the winter
17 strategy for this year is to reinvest in having those peer
18 workers in the ED.
19
20 Attracting activity financially is the hard part with
21 peer workers, because they are not clinicians as such, but
22 we're working around that to try and actually show the
23 data, because we've got the verbal - everybody says how
24 wonderful it is to have somebody there, and we know that
25 having a person with lived experience sitting next to and
26 walking through the journey with somebody that presents
27 just calms everything down. It helps EDs understand our
28 consumers that are presenting but, more importantly, it
29 just provides a safety for those people that present in a
30 very busy and very chaotic ED.
31
32 People are there because they're really, really sick,
33 and you bring somebody in that's mentally very unwell, it
34 just sort of exacerbates everything. So having somebody
35 with a lived experience, I believe, is probably one of the
36 most beneficial projects that we've ever invested in.
37
38 THE COMMISSIONER: Because we started early, I might give
39 people a break now. So we'll have a break until 11.25.
40
41 **SHORT ADJOURNMENT**
42
43 THE COMMISSIONER: When you are ready, thank you,
44 Dr Waterhouse.
45
46 DR WATERHOUSE: Just before the break we were talking
47 about the peer workers and, Ms McFarlane, you mentioned

1 that these were included as part of a winter strategy. Is
2 this because there is a seasonal aspect to the problem, or
3 because you have particular funding available for winter
4 strategies?
5
6 MS McFARLANE: So, yeah, there is a seasonal aspect, we do
7 have more presentations of mental health consumers and drug
8 and alcohol consumers over the winter period. That has
9 a lot to do with social factors, so homelessness, personal
10 conflicts - so it is - definitely there is an increase over
11 the winter period. But we did also have the availability
12 of funding, so we decided that this was a worthwhile
13 project to invest in and, like I said, we had lots of
14 qualitative evidence to show that it was a success. So
15 this time around we're actually trying to build some
16 qualitative data to capture the activity that is provided
17 in that ED presentation and how effective it really is in a
18 data activity based way.
19
20 DR WATERHOUSE: Has there been any reduction in the number
21 of patients who don't wait to be seen as a result of this?
22
23 MS McFARLANE: I would not be able to answer that right
24 now because I don't have the activity right here in front
25 of me, but certainly what it does is it eases the pressure.
26 So whether they don't wait is another thing. The why they
27 don't wait, it's not - it's not because they're not being
28 supported anymore, because the support is there. It
29 doesn't mean that everyone is going to stay, but certainly
30 it provides that safety component for the person, and for
31 their carers. They actually have somebody else that can
32 talk to them as well and support them. Especially while
33 somebody's maybe being assessed and the carer is not there
34 with them, the peer worker can actually sit through that
35 process with them and help them understand it.
36
37 DR WATERHOUSE: Dr Kealy-Bateman, did you have any comment
38 at all you would like to make about the peer workers before
39 I move on?
40
41 DR KEALY-BATEMAN: Yes. You certainly can't arrive at a
42 "did not wait", you can't score that if someone goes to
43 actually speak to the person, speak to them and write
44 a clinical entry, and the peer workers are just absolutely
45 marvellous. They have lived experience. They know what
46 it's like to stand in the shoes of the person who has had
47 problems with mental health and/or drug and alcohol. The

1 chief psychiatrist of Queensland, John Reilly, published
2 a great study a few years ago looking at 2,500 patients and
3 50 per cent of them had comorbid drug and alcohol problems
4 so we've strategic focus on thinking everyone has a drug
5 and alcohol problem as well that they are self-medicating,
6 until proven otherwise. So having people who are peer
7 workers who kind of get it is just amazing. When someone
8 fronts up and says "I know you are here, someone is coming,
9 I will help you navigate this system", the relief is just
10 unbelievable. It really makes a difference. I can't give
11 you the exact data but did not wait, just basically
12 disappears when you have got it there.
13
14 You know, some of our peer workers, we often have as
15 employees of the month, they are just stand-outs.
16
17 DR WATERHOUSE: Do you have peer workers who identify as
18 First Nations people and, also, non-Indigenous peer
19 workers?
20
21 DR KEALY-BATEMAN: Yes.
22
23 DR WATERHOUSE: Are they matched up to individuals, or is
24 it just whoever happens to be there on the day.
25
26 DR KEALY-BATEMAN: I am sorry, I have a hearing problem.
27 I didn't hear your question.
28
29 DR WATERHOUSE: Sorry. Are they matched up according to
30 Indigeneity, or is it just whoever happens to be working
31 there at the time?
32
33 DR WATERHOUSE: We might go back to your outline,
34 Ms McFarlane. I note that you have listed there the
35 community mental health and drug and alcohol services that
36 are face-to-face, and then over the page you've got the
37 virtual services. I will come back to those, but I just
38 want to get a little bit more information about the
39 specialised programs and initiatives that you have listed
40 there on the second page. This is under paragraph 4(d).
41 So can you tell me a bit about the mental health drug and
42 alcohol intellectual disability clinic?
43
44 MS McFARLANE: Yes. So just post COVID, the third wave,
45 there was substantial funding made available for vulnerable
46 populations. So every LHD and mental health provider were
47 able to actually submit models that they thought would be

1 beneficial. We had already had some mental health
2 intellectual disability funding to set up across the state
3 prior to that, so this just enabled us to actually be able
4 to look at a specific model that we could embed. The
5 population is quite large. It used to be catered for - we
6 had, on the Bloomfield campus, Riverside, which was an
7 intellectual disability hospital. Those consumers were
8 then all placed into community placement. They were
9 overseen by an actual intellectual disability psychiatrist
10 who wasn't affiliated with us at that time. He
11 subsequently retired, as they do, and so we took on that
12 population.
13
14 So we have a dedicated psychiatrist now based, because
15 of this funding, who is able to offer a virtual clinic
16 across the district, as well as some face-to-face, and
17 I think she's also providing some support to Broken Hill,
18 because there is a population there and they don't have
19 a psychiatry support like we do. So it's sort of growing
20 in its own nature, based on the population.
21
22 But her clinics are very well received. She's doing
23 some amazing work and she actually works with towns, so
24 there are particular towns, such as I think it's Condobolin
25 that have quite a large population, or somewhere like here
26 that has Westhaven which also has a large population of
27 intellectual disability, so she can support those
28 communities and those teams with the work that she does,
29 and we've been able to supply nurses to work with her. So
30 there are 2 FTEs with her. There are only three of them,
31 but doing that hybrid virtual and some face-to-face has
32 been a really successful model.
33
34 DR WATERHOUSE: These are people with an intellectual
35 disability who also have either a mental health or drug and
36 alcohol problem; is that correct?
37
38 MS McFARLANE: Correct, yes.
39
40 DR WATERHOUSE: When you say it is quite a large
41 population, how many would we be talking?
42
43 MS McFARLANE: I think there is around 200 plus that she's
44 currently actually looking after. The idea is most of them
45 are already integrated into the community, so it's actually
46 keeping them monitored to ensure that they don't - their
47 mental health conditions or their behaviours don't escalate

1 to where they need to come into hospital.
2
3 DR WATERHOUSE: Looking then at the fifth one on that
4 list, the rural adversity mental health program, can you
5 tell us a bit about that?
6
7 MS McFARLANE: Yes, that came about because - first, it
8 was drought, then there was flood, then there was fire, and
9 then there was a mouse plague. So we were able to receive
10 funding from the state to implement a program, and this is
11 a lived experience workforce as well. So these are people
12 that are farming communities and people that live in
13 farming communities, who are actually employed to go out
14 and actually talk to people who have some mental distress
15 due to whatever is going on with the weather or with what's
16 happening in the space in their communities, and they then
17 link back to our community mental health services.
18
19 So it's really a program where you can connect at
20 local community level, so they'll do fundraising events,
21 they'll go to whatever is happening in the town, they might
22 have a stall that they set up, but they will also just go
23 from farm to farm to farm and talk to people that are going
24 through adversity, or small businesses in small
25 communities, and just monitor their distress. And if they
26 need to refer them on, then they can. So we have strong
27 linkages to community mental health services, so if there
28 is a more acute risk, then they can refer them up, or if
29 there is other NGO providers that they know that are in the
30 town or coming to the town, then they can refer them to
31 those as well.
32
33 DR WATERHOUSE: Are those people clinicians, or have they
34 had some sort of training to help them deal with people who
35 are in distress?
36
37 MS McFARLANE: They are not clinicians, and we provide all
38 the education and training. Most of them have a cert III
39 IV, which they are able to - we pay for them to do their
40 education and training and then we support them throughout
41 their journey.
42
43 DR WATERHOUSE: How does that relate to the rural response
44 and recovery team that is below that?
45
46 MS McFARLANE: Yes, no, that's just - it keeps growing.
47 As you are aware, the adversities didn't disappear after we

1 had a drought or a flood, so we knew that different
2 communities needed different aspects, and you will see - so
3 we've got a rural adversity mental health component, which
4 is - they are clinicians, and they are out there promoting
5 services that we can offer, either at an acute level, or
6 services that are available on the ground in their local
7 communities, and they link in with the rural adversity
8 teams. So they all do similar work, but the rural
9 adversity team are very much lived experience driven and
10 community based, so the town they work in is the town that
11 they deliver the service in, whereas the RAMHP is more
12 across the district, and it's also - has linkages back to
13 I think it's the Peregrine Centre, but there is
14 a university component that has linkages with them because
15 it's all based around research.
16
17 DR WATERHOUSE: The Safe Haven facilities that you have in
18 Parkes and Dubbo, can you tell us a bit about those?
19
20 MS McFARLANE: Yes, so again this was in regards to the
21 Towards Zero Suicide initiative that the state were rolling
22 out, and every LHD had the opportunity to develop a Safe
23 Haven model, and the Safe Haven model is about an
24 alternative to ED. So we've heard today that, you know,
25 not everybody will present to ED, not everybody wants to
26 present to ED, or not everybody needs to present to EDs
27 either. And certainly people that are experiencing an
28 increased risk of suicidal thought, an ED is probably not
29 the most appropriate place, because, like I said, it's
30 hectic, it's very busy.
31
32 So the initiative was based from a Queensland
33 initiative, where the Safe Havens were originally
34 developed, and we had some training with Roses in the
35 Ocean, which were a peer-led organisation. So we had the
36 opportunity to develop - we looked at our suicide rates
37 across our district and we picked the population where
38 there were peak suicide risks and suicide clusters, and
39 Parkes was one of those and Dubbo was the other one. So
40 they were - at that time, they were the areas that we saw
41 that were at the most need of something like this.
42
43 So we worked really closely with the community,
44 because at the end of the day, it's a community-driven
45 service, and we wanted to make it spaces that were within
46 the community, weren't hidden away but provided enough
47 privacy that people felt comfortable that they could go and

1 talk to somebody, they could go down town and there is
2 a shopfront and behind that shopfront are people with lived
3 experience that have gone through the journey of either
4 a lived experience of suicidal ideation or a carer of
5 somebody that has suicided.
6
7 So across the LHD, there are two of them; across the
8 State there are multiple versions of them. Some of them
9 went down a complete peer-led service, which is what we
10 did. Some of them have got some clinician and some
11 peer-led service. So both of ours are completely led by
12 people with lived experience. They link with our community
13 mental health teams, so they are supported in that regard.
14 So if somebody does present and they are concerned, there
15 is just a phone call away and the community mental health
16 team can actually assist them. They also link with the EDs
17 in the same way, so that if they are concerned with
18 somebody that has presented that's more at risk than what
19 they are feeling comfortable with.
20
21 They've been hugely successful because they are,
22 again, people that live in the community, have worked
23 within that community and can actually navigate the system
24 with people.
25
26 Again, they are not clinicians. Some of them have
27 come from a clinical background but just working as a peer
28 with a lived experience now. So we support them with
29 training and education and they are part of that community
30 of practice for peer workers.
31
32 DR WATERHOUSE: Do they link in with the suicide
33 prevention outreach program in Dubbo, at least, and there
34 is one in Orange?
35
36 MS McFARLANE: Yes, they do. We say it's a program - we
37 have a total FTE of four for the suicide prevention
38 outreach team to cover our entire district. So again, we
39 had to get very - we had to think very carefully about how
40 we supported four FTEs to be able to navigate, which is
41 a very vulnerable population and it's very trauma - it
42 places a lot of trauma on the clinicians and the people
43 that are working with those people. So we've got to - we
44 had to wrap them around into an actual team environment so
45 they weren't working in isolation.
46
47 So the suicide prevention outreach teams, which are


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1 based in Dubbo and in Orange, actually are a part of the
2 acute continuing care team, which is the community mental
3 health team, so that they have a greater body of people
4 wrapping around them. Because they go out to people's
5 homes, they go and see people after they have left
6 hospital, if they have had a suicide attempt. So it is
7 really important for them to have that bigger team to come
8 back to and actually be able to debrief at the end of the
9 day.
10
11 DR WATERHOUSE: Have the Safe Havens been designed with
12 First Nations cultural principles?
13
14 MS McFARLANE: Absolutely. So for our mental health
15 service - I can't speak for the whole state but ours in
16 particular - every service that we deliver is co-designed
17 with First Nations and people with a lived experience. So
18 it never used to be that way, but it's certainly something
19 now that we - no service will now open without those two
20 components.
21
22 DR WATERHOUSE: Dr Kealy-Bateman, did you have any
23 comments you wanted to make on some of the specialised
24 services either that I have highlighted or other ones that
25 have been rolled out in the district?
26
27 DR KEALY-BATEMAN: No, I think Helen has done a great job.
28
29 DR WATERHOUSE: Thank you. All right. If we just go,
30 then, to the Mental Health Emergency Care service, where
31 you have covered from paragraph 5 onwards - and
32 I understand that has the abbreviation MHEC; is that right?
33
34 MS McFARLANE: Yes.
35
36 DR WATERHOUSE: Can you tell us about the MHEC service?
37
38 MS McFARLANE: The MHEC service has probably been in
39 existence for a good 20-plus years. It started as a phone
40 service. It has the same number now as it did back then,
41 and that service evolved from a telephone service to
42 a video consultancy service, still with the phone
43 component, and then it sort of rolled out across the state.
44 So there's many other mental health emergency phone access
45 line services that do video consultancy.
46
47 What we do differently to the rest of the state - and

1 I think there are three other LHDs that are still doing
2 a MHEC service like we do - ours is based in our LHD, so
3 our staff are all from somewhere across the LHD, the
4 majority of them are based in Orange because that's just
5 where the service started, but you can work anywhere. We
6 have a psychiatry input for two days a week during business
7 hours, for 24/7, because there is always a psychiatrist on
8 call. They are senior mental health clinicians, so most of
9 them are nurses but we've now moved into having a more
10 multidisciplinary approach, so we have allied health that
11 work in the space as well, and they are able to pretty much
12 beam into any service that requires their support or
13 assistance across the district.
14
15 Initially it was to support those rural/remote smaller
16 hospital sites with people presenting, but more recently
17 it's sort of evolved into supporting anybody that kind of
18 needs that emergency care for psychiatry assessment, even
19 in the base sites. So not every site has a consult liaison
20 in their ED all the time due to staffing issues, so MHEC
21 are able to actually support EDs as well with video
22 assessment of people that present.
23
24 They are restricted to assessing in gazetted sites
25 and, as we've talked about, there is limited gazetted
26 facilities across our district, but, you know, due to
27 transport issues, trying to get people into hospital is
28 complicated, so MHEC are actually beaming in to many spaces
29 now that they wouldn't necessarily have beamed into before.
30
31 DR WATERHOUSE: When you say they are limited to beaming
32 into gazetted sites, can you explain that a bit further?
33
34 MS McFARLANE: So by the nature of the Mental Health Act,
35 a person that is placed under a schedule is to be
36 transported to the nearest gazetted facility, so that's
37 a facility that under legislation means that somebody under
38 a Mental Health Act can go to that facility and be assessed
39 in that facility. Across our district, we have, of course,
40 Orange, Bathurst and Dubbo that are gazetted facilities,
41 and we also have Mudgee and - I don't know if there is
42 another one.
43
44 DR KEALY-BATEMAN: There is one more. I just can't think
45 of it.
46
47 MS McFARLANE: But in those smaller sites, you actually

1 have to have a facility with a safe assessment room,
2 because there is legislative guidelines around what a
3 gazetted unit has to have, and you have to have the
4 workforce to be able to support people that are staying
5 there for longer than the short period of time that they
6 are meant to. So you can present anybody to any hospital
7 across our space, but if you're going to keep them for an
8 extended period of time, you actually have to have that
9 legislative requirement to support them.
10
11 DR WATERHOUSE: Dr Kealy-Bateman, can I ask you from
12 a clinical perspective, how do you find that remote service
13 working, if it has to beam into an ED where there is no
14 psychiatrist?
15
16 DR KEALY-BATEMAN: Before working - I've worked here for
17 15 years and before working here I was trained and then
18 I worked as a psychiatrist in the Illawarra Shoalhaven
19 area. So I'm used to working across distance and I'm used
20 to working with telehealth and in its embryonic form as
21 well, and this area does it really well, and MHEC is an
22 absolutely fantastic service. MHEC has evolved to
23 operationalise a very standardised service where you can
24 provide high quality psychiatric assessment of a person in
25 an ED, an emergency department type environment, whether
26 it's in a very small health facility or a larger health
27 facility, or to provide telephone advice to a family
28 member, a consumer, healthcare person that rings up needing
29 health advice, to police, to a GP, et cetera. And then
30 they have a psychiatrist on call from the Orange pool, from
31 the southern half of our district, but also a psychiatrist
32 on call from the Dubbo half of our district, 24 hours
33 a day.
34
35 So we've always kind of got that backup. You know, if
36 one of us doesn't have phone access because we're down
37 a valley or something, that's great, so we've kind of built
38 in a really, really secure system for everyone. I think
39 the community sometimes gets a little bit concerned that we
40 don't have access to care, but we've built in safeguards
41 that we do have access to care all the time and good
42 advice. So that's really good. I want to make that
43 comment.
44
45 What is difficult about these long lines of transport
46 is that people are over long distances and there are some
47 aspects about the Mental Health Act that have actually

1 caused us a few hiccups. So, for example, if a magistrate
2 sees someone in Walgett, Walgett is 280 kilometres away,
3 and determines that they need to be taken - or the police
4 determine that they need to be taken to the nearest
5 gazetted facility, so Dubbo is the nearest gazetted
6 facility, 280 kilometres away, and this is where the Mental
7 Health Act has been written in a very metro centric way and
8 I felt that 15 years ago when I was a medical
9 superintendent of Shellharbour hospital as well, the Mental
10 Health Act is not fit for purpose in terms of people,
11 culture, our resources.
12
13 So we then need to have to start to waste money with
14 police and ambulance and all sorts of people, transporting
15 a patient who may not need to be transported 280 kilometres
16 away - for Aboriginal people - from country, for anyone,
17 away from family and people they love, just so you can
18 front them up in front of a medical officer, and it doesn't
19 always need to be a psychiatrist, but usually
20 a psychiatrist, at Dubbo hospital. That is just
21 ridiculous. So a whole cascade of wasting stuff ensues.
22 So I do really feel that.
23
24 But we also feel that anyway when we do need to
25 transport patients for health reasons. What would be
26 better, in terms of the Mental Health Act, is if it allowed
27 us to make those assessments in the periphery with our
28 wonderful MHEC service, with the advice of psychiatrists
29 and other medical officers on the ground and other virtual
30 services beaming in on the ground to make a determination,
31 a disposition statement - determination about the person
32 before us: do they need that transport? Yes, we're happy
33 to provide that transport should someone need that health
34 care at another site, but not to waste the resources
35 because they need it for a reason required under the Mental
36 Health Act.
37
38 We do have a lot of problems with transport, because
39 it's always difficult to work out: well, should we
40 transport this person because they're having a heart attack
41 or they've got a problem with their bowel that might become
42 very, very difficult soon, or do we transport this person
43 because they're acutely suicidal or psychotic. So we have
44 very difficult decisions to make amid resource constraints.
45 Of course, taking police out of an environment where there
46 might only be two in the town, that's very serious, because
47 then we may not be dealing with a serious domestic violence

1 issue in the town. So rural communities have to make
2 critical decisions about the resources they have. So
3 I think we want to make our legislation reflect what we
4 need to do with the resources we have, and at the moment,
5 I think that it doesn't. But otherwise, we do the best we
6 can with what we've got.
7
8 DR WATERHOUSE: You're referring in your outline to - and
9 I think you have just used the word "metro centric", in
10 relation to the Mental Health Act. So is my understanding
11 correct that the change you would like to see is that
12 people can be assessed and kept where they are if the
13 assessor deems that safe, rather than have to take them to
14 a gazetted hospital or a facility to make that decision?
15
16 DR KEALY-BATEMAN: I believe THAT the Mental Health Act -
17 and we have given feedback over many, many years -
18 I believe that the Mental Health Act should reflect that
19 a gazetted facility in a rural area should be able to
20 effectively beam out at a distance and be in all these
21 sites. We shouldn't have to transport someone to
22 a gazetted facility in a black-and-white way just so that
23 they are there. We should be able to make a disposition
24 decision in the periphery, because that's in the best
25 interests of the person, their family, the health service,
26 all the transport services and the community, and that's
27 sensible. That's a commonsense decision. So somehow that
28 needs to be finessed in the legislation.
29
30 THE COMMISSIONER: You have said you have thought that for
31 15 years and you've given feedback over many, many years.
32 Who is the feedback being given to?
33
34 DR KEALY-BATEMAN: We feed that back to the ministry, we
35 feed that back when we're in meetings. But I think it
36 keeps falling on deaf ears is a problem that we have to
37 solve locally. I haven't --
38
39 THE COMMISSIONER: You may have just answered my next
40 question. What has been the outcome of the feedback you
41 have provided?
42
43 DR KEALY-BATEMAN: Well, it continues to be that - it's
44 continued to be that the best decision is to actually
45 transport the patient to the hospital, the gazetted
46 hospital, and we've continued to have business as usual.
47

1 But we really feel it here, in a place like here, and
2 the example I gave is a really good example, it's really
3 felt here, because at a place like Walgett you've got
4 a different police force, you've got a different set of
5 ambulance services to the ones in the region in Dubbo, and
6 all their crews need rest. So when they try to transport
7 a patient 280 kilometres, it's a disaster, because they
8 can't coordinate services easily, they then put multiple
9 services on the road for long periods of time. It wastes
10 a day or so of operations. It's a really, really difficult
11 thing to do. But if we could just make a decision in the
12 periphery, or where the person is, a disposition decision,
13 and then transport only if needed, that would be more
14 sensible.
15
16 DR WATERHOUSE: Can you just clarify for us what you mean
17 by a "disposition decision"?
18
19 DR KEALY-BATEMAN: Should they come or go to Dubbo, and
20 then we could decide. So not everyone that is - that
21 police or the magistrate wishes to come into a mental
22 health facility comes to a mental health facility. Less
23 than half do. So we would save a lot of mucking around if
24 we didn't. But we would still provide good care and
25 recommendations.
26
27 DR WATERHOUSE: So more than half would be able to stay
28 in situ having been assessed virtually.
29
30 DR KEALY-BATEMAN: I'm pulling that figure from the air,
31 but approximately half of people go back to --
32
33 MS McFARLANE: I was just going to add, with MHEC in
34 particular, a diversion from having to bring people to
35 hospital, it's there, the data is there and it shows that
36 it's a very worthwhile proposition. I think just to add
37 with what Warren's saying, we have to invest in the
38 community. So the workforce needs to be there to support
39 those small communities to be able to keep people within
40 the community that have mental health and drug and alcohol
41 issues.
42
43 So it's not just being able to keep somebody in the
44 hospital because the Mental Health Act then allows us to;
45 it's actually supporting that hospital to have that
46 integrated care approach to ensure that all the right
47 stakeholders are invested in that community to be able to

1 support that person to stay there. Because no, not
2 everybody needs to come to our services. At the end of the
3 day, they should only come because that is the last resort.
4 It's what I call the hiccup in their journey. Inpatient
5 beds will always be needed and we'll always be there, but
6 we're just a hiccup in their journey. If we can invest in
7 the community to keep people in the community, and that
8 means the Mental Health Act supporting us to do that, then
9 that's where the resources need to be invested.
10
11 DR WATERHOUSE: You mention in paragraph 8 of your outline
12 that there are three services that can form MHEC, the
13 mental health triage, the Mental Health Emergency Care
14 assessment, and clinical advice. So can you just describe
15 how those three work together?
16
17 MS McFARLANE: Yes. So basically what MHEC is is the
18 pointy end. It's the entry door to our mental health
19 service. So they will do a triage and that triage will
20 then trigger a determination of what that person needs in
21 regards to their mental health care. And it's based in
22 increments of time. So if it's a high acuity and they need
23 instantly to be transferred to either Dubbo or to Orange,
24 then that will be determined based on that triage.
25
26 They'll also do the assessment component of that, so
27 that they get as much information and detail from the
28 person as they possibly can, especially being able to beam
29 in and being able to talk to the person or to their carer
30 or support network is really, really critical in that, and
31 then they can help navigate. So if they don't need to come
32 to Orange or Dubbo for a more intensive psychiatric
33 admission, then what services are provided within their
34 community, and that could be the community mental health
35 team, it could be their GP. It would be anybody that's
36 a part of their support network.
37
38 So that's kind of the journey once you ring a MHEC
39 service, if you are ringing for a person. But like Warren
40 said, a GP can ring and actually ask some of that advice
41 themselves. They might have a person sitting in the GP
42 space. MHEC is now able to beam into that GP space and
43 actually communicate with the person sitting there whilst
44 it's happening. So they are the sorts of important details
45 around MHEC. It is the pointy end, which is why we sort of
46 morphed into having a virtual community mental health
47 service available now, because MHEC is about triage,

1 assess, refer, and it should be that succinct, hopefully,
2 with everything going in the right direction, and then you
3 can have a virtual community mental health service
4 available if there is a town that doesn't physically have
5 that community mental health on the ground.
6
7 DR WATERHOUSE: So I will come to the virtual service in a
8 moment, but just one more question in relation to this. So
9 would it be the case that a person presents to their GP, or
10 is becoming unwell at home and their carer recognises that,
11 they ring up and get advice - would there then be
12 continuity in terms of who assesses them once they are
13 transferred to a facility and so on?
14
15 MS McFARLANE: With our MHEC service, they will actually
16 speak with the psychiatrist that's on call. If they are
17 coming in to a hospital setting, such as the Orange or
18 Dubbo mental health services, the psychiatrist then talks
19 to the admitting psychiatrist in the unit, so that
20 information is passed on. A lot of the time they do have
21 to come through the ED service, and that's where it all
22 gets - it sort of delays the transition, and that's because
23 we need to make sure that people, just like anybody else
24 presenting, gets that medical review to make sure that
25 there's nothing organic, so, you know, we haven't got
26 a physical issue that's actually causing the mental health
27 problem. So to get them medically cleared prior to coming
28 in.
29
30 We do take direct admissions in Orange. It doesn't
31 happen in Dubbo for direct admissions into the acute unit,
32 they all go through ED. But in Orange we can, if we know
33 the person. So it is based on that, so there is as little
34 hiccup in the transition as we can possibly make with MHEC
35 and it really does come back to transport is the biggest
36 hiccup, because that can delay the transfer. So if the
37 determination is they need to come to hospital, it's then
38 the whole navigating, well, how do we get them there as
39 quickly as we can.
40
41 DR WATERHOUSE: Are the psychiatrists that work for the
42 MHEC service local psychiatrists, or could they be living
43 elsewhere in the state?
44
45 MS McFARLANE: They are all fly in, fly out. They are
46 VMOs, but they come here. They are in community, they are
47 not working anywhere else across the state. They are

1 actually here. We invest - like we do do a lot of virtual
2 service, but the investment needs to be within our
3 community, our LHD, because geographically it's huge, and
4 understanding each of our communities is really difficult,
5 which is why we've grown the MHEC service to be a locally
6 based service rather than farmed it out to a private
7 organisation.
8
9 DR WATERHOUSE: Let's have a look at the virtual community
10 mental health service. I would like to just understand how
11 that model works and, in particular, how it integrates with
12 the outreach service face-to-face.
13
14 MS McFARLANE: Yes. So the virtual community mental
15 health service came about again because of some funding
16 post COVID. What we found during COVID is there was
17 significant amount of small remote towns that actually
18 didn't have on the ground. Like I said earlier, you know,
19 every community would like a full community mental health
20 service there available to them every day. We don't have
21 the workforce to be able to do that. So this sort of
22 evolved from that space.
23
24 So our community mental health services across the
25 three hubs all have an outreach component, which means the
26 acute community mental health team will go to certain
27 towns, either at a fortnightly basis or a monthly basis, to
28 run a clinic, and so that's how you sort of book in to see
29 your community mental health team. But there are even
30 towns that are so remote that they don't even have that
31 outreach component. So they have to travel to the next
32 nearest town that has the availability.
33
34 So we figured: well, if we can do it virtually, what
35 would that look like? So we basically have developed an
36 acute community mental health team that is virtually
37 existing, that supports these towns - so if a person
38 requires a community mental health service, then GPs can
39 contact them, the person themselves can contact them, and
40 they link within those communities, so it might be through
41 a community health centre, it might be through the
42 Aboriginal Medical Service, whatever is available in that
43 town that that person can present to, and they can work
44 with that community mental health team.
45
46 Then they can also pass it on to a face-to-face, which
47 is where the community mental health team are coming for

1 one of those clinics, so in between those clinics, if
2 something happens, you've got a virtual community mental
3 health member that can actually support you through your
4 journey.
5
6 DR WATERHOUSE: You mentioned in paragraph 15 that you
7 have a good relationship with two gaols, in Wellington and
8 in Bathurst, and that you also have a strong relationship
9 with the Department of Communities and Justice. Can you
10 just tell us a little bit more about the role that the
11 virtual community mental health team plays, or service
12 plays for the gaols?
13
14 MS McFARLANE: It's not really just the community mental
15 health - like everybody within the district has
16 a relationship with the gaols in some way or another.
17 Mental health certainly in-reach into the gaol system at
18 Bathurst to provide some support for mental health
19 conditions within Bathurst, and they were doing it in
20 Wellington. There were some issues with the mice plague
21 I think and so Wellington was not at capacity for a while,
22 but we've done a lot of work, because a lot of the people
23 that are released from gaol come out on what we call the
24 opioid treatment program. So our drug and alcohol service
25 has really developed a strong link with those communities,
26 because they are coming out and we're the service that's
27 providing the methadone program for them. So those
28 linkages are really important.
29
30 DCJ especially around - since COVID, with our
31 integrated care service in the district, mental health and
32 DCJ in regards to homelessness, because we did find an
33 enormous amount of people that were suffering with
34 addictions and with mental illnesses that had never had any
35 contact with any of our services at all living in
36 stairwells or living in homes of, you know, where the
37 home's only supporting six people, there might have been
38 20, because that's just how the community supports
39 themselves.
40
41 So our relationship with DCJ is growing, because they
42 are leading that process in the homelessness space, so
43 we've now started to try and implement what does that look
44 like across our district. We know that there's a huge
45 number of homelessness people, there is a huge number that
46 have mental illness and a co-morbidity of drug and alcohol,
47 plus all their other social issues, like no job, or they've


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1 lost a job, or their family's disconnected from them, so
2 bringing those stakeholders together has been really
3 important. And because we have two major gaols, we have
4 families that come with those people that relocate to be in
5 the towns where their person is residing in, and so we've
6 got a bigger population, which comes with intergenerational
7 problems as well.
8
9 So bringing all those people together is what we do to
10 try and actually navigate, okay, well, if homelessness is
11 the issue, we haven't got homes, what's the next step that
12 we have to do to support people? So working with Housing
13 Plus, and so it's those sorts of conversations that we try
14 and navigate for people as they come out of gaol.
15
16 DR WATERHOUSE: Dr Kealy-Bateman, I think you mentioned
17 before that you had been the only adult psychiatrist in
18 Wellington at one stage. Was that a significant part of
19 your role, dealing with some of the people who are either
20 in gaol or had been released?
21
22 DR KEALY-BATEMAN: Yes. So that's an appropriate
23 situation to be the only psychiatrist serving Wellington,
24 so the World Health Organization says you should have one
25 psychiatrist - well, one full-time equivalent psychiatrist
26 or psychiatric registrar per 10,000 people. Wellington's
27 well under 10,000 people. I look after a team of other
28 healthcare workers there, and I go there about one day
29 a week and I'm on call for there.
30
31 Most of the patients in my clinic identify as
32 Aboriginal and a lot of them have been in gaol, and so
33 I reflect - I agree with what Helen has said.
34
35 I have a good relationship with people who work in the
36 gaol and some of our ex nursing staff members work in the
37 gaol, and it's good to be able, with permission, with
38 consent, to be able to share information both ways.
39 Because the gaol is a large employer, we also know a number
40 of people who work in the gaol, because we're part of the
41 community. The gaol is a very, very large part of the
42 community as well. So we work with the community and DCJ.
43
44 DR WATERHOUSE: Is there any other comment that you would
45 like to make about the virtual community mental health
46 service?
47

1 DR KEALY-BATEMAN: Look, I think the virtual community
2 mental health service has been really fabulous. We have
3 towns everywhere that have very, very small populations,
4 from 50, 100, 500, and we can't practically put a community
5 mental health team everywhere, and I would like people to
6 have care everywhere, and it's been an incredible
7 innovation. I've even managed to do, in my own work in
8 following up patients who have moved - they've even managed
9 to connect in by some of our NSW Health portals, including
10 Pexip, from their own mobile phones, so I've been able to
11 kind of interview them. I've had to get them to hold
12 still, it's been quite funny. "Please put the phone down,
13 stop moving it about".
14
15 But the quality - if you get people to kind of
16 understand the social framing and the rules, the quality of
17 the interview where I can see the expression on their face,
18 see - like see the emotion, be able to interpret what
19 I need to interpret as a specialist is very, very high, you
20 know, "Please have good lighting. I'll have good lighting
21 too", et cetera. We've come a long way in 25 years and we
22 can provide really good care if we work hard to get it
23 right. So I'm so pleased about these innovations.
24
25 DR WATERHOUSE: Ms McFarlane, you talk about, in
26 paragraph 16, that in your view there needs to be greater
27 investment in community mental health. Can you give us an
28 outline, is it more of the same? Is it more on the virtual
29 side or more on the outreach, a combination, or are there
30 particular initiatives you would like to see funded?
31
32 MS McFARLANE: Yeah, so I guess I want to get across that
33 within mental health drug and alcohol, completely virtual
34 is not ideal. You need to have a hybrid model. So
35 wherever possible, you have a virtual component that
36 supports an on-the-ground face-to-face component.
37
38 Again, geographically, our distance doesn't always
39 make that easy, but that's the sort of model that we're
40 trying to persevere.
41
42 My comment around investing in community mental
43 health, because we're an LHD that does mental health and
44 drug and alcohol as one, so I always refer to it as mental
45 health drug and alcohol, is that seriously, since the
46 Richmond report, which was back in the '80s, and the
47 investment was to put everybody out of hospital and into

1 the community, but even back then they didn't support the
2 community to actually be able to deliver on that model. So
3 we've forever been trying to play catch-up. And community
4 mental health services, as they exist today, existed for
5 Orange and Dubbo for the last 30 years. It hasn't changed.
6 So the workforce, we have got more funding to actually, you
7 know, put more investment into community mental health, but
8 the physical environment that they exist in hasn't changed.
9 There is no infrastructure investment for community mental
10 health unless you are delivering a new service.
11
12 So if you are building a new hospital, you might have
13 a community mental health team that's part of that
14 component so you will get a new community mental health
15 service.
16
17 Across the state, the models of care for community
18 mental health are not consistent either. So many LHDs have
19 community mental health services, but they all do things
20 differently, and even in our district, we do things
21 differently depending on the town that you are actually
22 delivering the service from. So one of the things that I'm
23 invested in is to actually look at our community mental
24 health services to provide some consistency with a model of
25 care that it doesn't matter where I work, I can go to that
26 community mental health service and I know what I need to
27 do and I know the model of care that I'm working under, and
28 I think that has been a big component that we haven't done
29 very well.
30
31 I think the other part of it is we've grown and
32 matured as an organisation in that it's not just community
33 mental health drug and alcohol anymore for person-centred
34 care. You need to have all the stakeholders around the
35 table. So, you know, a one-stop-shop is what we've talked
36 about and we've tried to do that with the LikeMind service
37 in Orange. And it is scalable, you just need to have the
38 primary care aspect working with the mental health care
39 aspect, working with the drug and alcohol aspect, because
40 these individuals have enormous amount of co-morbid
41 problems, and mental health is stigmatised, drug and
42 alcohol is stigmatised, so that's the sort of thing that
43 sort of shines on them. Yet everything else that's wrapped
44 around them sort of gets missed.
45
46 So I think if we're going to invest in communities and
47 invest in community mental health drug and alcohol

1 services, then we need to look at that integrated approach,
2 ensuring that primary care is sitting alongside of it. But
3 we want to make sure that primary care has the same
4 clinical governance as we're expected to deliver for our
5 consumers. I think that's where we sort of get nervous
6 with NGO providers, because we need to oversee that
7 clinical governance to ensure that it's evidenced best
8 practice that they are getting, that this person is getting
9 exceptional care, and we know it's exceptional care because
10 we've got to meet all these specifications.
11
12 So that's kind of - you know, sorry, a bit of my rant,
13 but I think if we invest in communities to invest in that
14 integrated care approach, then we will keep people out of
15 hospital much longer, and it will become that little hiccup
16 in their journey, because they really need to come to
17 hospital rather than they come to hospital because we're
18 here and that's where everyone should go.
19
20 DR WATERHOUSE: So part of that you have just said is
21 building workforce, and if I can just go to you,
22 Dr Kealy-Bateman, you talk in your outline under 5(a) about
23 workforce and having too few people with high levels of
24 competence, and that you need to be innovative to address
25 the gap. You said that you are on the cusp of being able
26 to fully train as a psychiatrist in Dubbo. Can you tell us
27 a little bit more about that?
28
29 DR KEALY-BATEMAN: Yes. So we deliver health care at high
30 levels of competence. There is no doubt about that. The
31 health care we deliver is fine and it's accredited. So
32 there is not a question about the level of health care we
33 deliver.
34
35 But when you start to move into rural regions, the
36 capacity to attract health care staff diminishes, as you
37 move away from the city. I can speak in terms of
38 psychiatry and say there are hundreds and hundreds of
39 psychiatrists that live in the eastern suburbs of Sydney,
40 for example. There are virtually none that live out here -
41 virtually, virtually, none. It a desert. So you reach
42 this point in the frontier in terms of trying to build the
43 workforce.
44
45 Orange is one of the smallest cities in Australia
46 where you can train in end-to-end psychiatry and meet all
47 the training experiences that you require to train as

1 a psychiatrist. And so it's a really, really unique place,
2 because you need to train in lots of different areas, from
3 old age psychiatry to child and adolescent psychiatry to
4 drug and alcohol, et cetera, and you need to train over
5 a minimum of five years. We can't meet quite all those
6 requirements in Dubbo at the moment. We're very close to
7 meeting all those training requirements.
8
9 The Department of Health federally is funding
10 something called the Psychiatry Workforce Program, which
11 allows little buckets of money that come with the provision
12 to have a full-time psychiatrist in training, as well as
13 their supervisor one and a half days a week, and we were
14 very lucky to get one of those roles in what's called
15 consultation liaison psychiatry, which is where the trainee
16 and the supervisor work seeing patients not in the
17 psychiatry beds in the hospital but all the patients
18 outside of that context. They might be in the surgical
19 ward, the medical ward, obstetrics and gynaecology, who
20 have mental health needs. That's a very specific area of
21 psychiatry, and that's a necessary part of training.
22
23 So we now have that rotation. We're just looking
24 forward to the next bucket of federal funding when we might
25 be able to get a child and adolescent team, and then we can
26 build end-to-end training here, just like the University of
27 Sydney is building the graduate program end-to-end training
28 here, because when we can have people essentially live from
29 cradle to grave here in a place like Dubbo, we actually
30 build the workforce proper, and they stay.
31
32 We do have a couple of psychiatrists in Orange and
33 Dubbo who have homes here and families here and live here.
34 So I might just add to what Helen has said. There are
35 people who aren't fly in, fly out, and that's really
36 wonderful, and that's how we build the workforce, and we're
37 doing that across all craft areas in medicine. We want
38 people to be here. And that is of strategic interest and
39 importance, in my view, for NSW Health and for the people
40 of New South Wales.
41
42 DR WATERHOUSE: When you talk about the rotations, are
43 they coming - those psychiatric registrars coming from
44 Orange, or from Sydney? How does it actually work?
45
46 DR KEALY-BATEMAN: Some of them come from Sydney. But
47 what we try to do is, in the first two years - so


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1 postgraduate year 1 and 2, we have what are called interns
2 and residents. We try and get them really, really
3 interested in psychiatry, and so three or four of the five
4 rotations per year, we manage to get those people to choose
5 psychiatry somehow, from Dubbo - not always - we don't have
6 enough room here, so we have a lot of competitive - sorry,
7 a lot of competition for our places in Dubbo, and so we can
8 only take two per year. But we try and get locals to
9 choose our places here. Some of them join the program in
10 Sydney, so they're effectively on rotation from Sydney and
11 they might go back to Sydney. But some of them choose the
12 local program here and our registrars from last year have
13 just gone back to Orange and they are working in Orange
14 now.
15
16 So we like people to try and stay and, quite frankly,
17 with home prices in Sydney, people now like to stay in
18 rural regions, which is really a happy story for us.
19
20 DR WATERHOUSE: Has there been any sort of response from
21 the College of Psychiatrists in terms of --
22
23 DR KEALY-BATEMAN: Yes, we've been working with
24 Professor Mat Coleman, who is from Western Australia. He
25 leads the rural project in the Royal Australian and
26 New Zealand College of Psychiatrists, and we've worked on
27 changing some of the training regulations to make them a
28 little bit more nifty and agile, to recognise that we don't
29 always have psychiatrists as often in a rural setting,
30 given they are sometimes fly in, fly out, particularly in
31 smaller locations. For example, Broken Hill may not have
32 the big presence of lots of child and adolescent
33 psychiatrists all the time, of course they don't, so how
34 can we structure our - what was once a very black-and-white
35 formula that you need this, you need that, you need this,
36 how can it be a little bit more flexible in these kinds of
37 frontier locations where you are at the edge of providing
38 these highly specialised services adjacent to rural and
39 remote areas to allow that opportunity for that end-to-end
40 training.
41
42 So the board of which I'm a member of the College of
43 Psychiatrists signed off on these new regulations that
44 recognise in areas for Modified Monash Model area 3 and
45 above - and we're sitting in area 3, and Orange is also
46 area 3 - that we can actually have these different training
47 regulations that provide actually slightly more support for

1 someone training in a rural or remote area, but in a more
2 agile way. So they get slightly more supervision but the
3 supervision is a little bit more agile, and of course it
4 includes audio-visual support as well. So we look after
5 them more but we're more agile about it.
6
7 DR WATERHOUSE: Did the federal funding drive the college
8 to change some of its requirements, or was it the college
9 driving it that then led to federal funding?
10
11 DR KEALY-BATEMAN: No, the federal funding and the college
12 requirements are two completely independent things. The
13 federal government is very interested in driving more
14 opportunities for the workforce in rural areas in
15 particular, and in the first batch of PWP funding in
16 New South Wales, there were only three places issued or
17 given out in New South Wales. Our health service won two
18 of them. One was in Orange and one was in Dubbo. And one
19 of the areas of focus, in terms of the funding, was for
20 Aboriginal health, and of course that was an area that we
21 excel in.
22
23 DR WATERHOUSE: And just to be clear for the record, the
24 PWP you referred to is the Psychiatry Workforce Program?
25
26 DR KEALY-BATEMAN: Yes, that's correct, and we're very
27 much hoping the government expands that further. The
28 reason the government is funding that is it recognises
29 there are areas of workforce shortage and need in
30 psychiatry in Australia, which has generally been somewhat
31 metro centric and concentrated on public psychiatry and not
32 in areas of special interest such as private psychiatry,
33 such as the country, et cetera. So it looks at funding
34 areas that we need to develop, you know, perinatal
35 psychiatry, a whole lot of areas. So it is really
36 targeting different areas.
37
38 DR WATERHOUSE: Although it has the word "workforce" in
39 it, it is a training program, though; it's not for people
40 who are already qualified as psychiatrists.
41
42 DR KEALY-BATEMAN: No, it is about training, and training
43 in the right areas.
44
45 DR WATERHOUSE: If we just go to paragraph 6 of your
46 outline, and you refer there - that covers the psychiatry
47 program we've just been talking about, but you talk more

1 broadly about the strategic workforce agenda and, in
2 particular, these Aboriginal health clinicians that we
3 spoke about earlier.
4
5 DR KEALY-BATEMAN: Yes.
6
7 DR WATERHOUSE: Can you tell us a bit more about that in
8 terms of the - so they end up with a degree from Charles
9 Sturt University; is that right.
10
11 DR KEALY-BATEMAN: That's correct.
12
13 DR WATERHOUSE: What does that degree entail? What does
14 it enable them to do?
15
16 DR KEALY-BATEMAN: So they end up with a basic bachelor's
17 degree, and in that time of doing the bachelor's degree,
18 they are embedded very heavily in our mental health drug
19 and alcohol workforce.
20
21 DR WATERHOUSE: So it is a mental health degree?
22
23 DR KEALY-BATEMAN: Yes, yes, and they end up doing quite
24 a lot of clinical work with, effectively, an apprenticeship
25 model, with high levels of Aboriginal mentorship as well.
26
27 My experience of working with this model goes right
28 back to when I first came to the health service in 2009,
29 and one of our original trainees went on to get an
30 executive MBA and really excel in terms of his leadership
31 in business and health care delivery in Australia. So some
32 of the people who have gone through that program have
33 really made an extraordinary contribution.
34
35 I must say, working with trainees is a really amazing
36 experience for me, both as a person but also as
37 a clinician, because you learn so much about how it is to
38 be a better community member and also you learn so much
39 about Aboriginal culture, and I reflect back to my earliest
40 experience. So I've had a decade and a half of growth
41 personally.
42
43 In terms of what they learn, they learn all the normal
44 things that our medical students learn, that our nursing
45 and allied health students learn when they are embedded
46 with teams. So they emerge as really quite strong
47 clinicians. They know how to see patients, write notes,

1 navigate teams and systems, be good advocates for patients,
2 but in a way of mirroring, they have also taught us, so it
3 is a journey for both of us and we are kind of a bit
4 heartbroken when they decide to then go and work for some
5 NGO or PHN, and then they go off and become executive
6 directors five years later somewhere else, because they
7 have actually gained really good skills from us equally,
8 but we're the learners too.
9
10 DR WATERHOUSE: Ms McFarlane, so the program has been
11 running since at least 2009 by the sound of things and you
12 said you have six trainees each year; is that correct?
13
14 MS McFARLANE: It is a three-year degree, so just like any
15 other degree when you go to university, so it is three
16 years, so there is always an intake year, and it's six that
17 we will support, and that's fully funded by us.
18
19 I think the investment in regards to it was about
20 actually ensuring that they brought their cultural
21 appropriateness to our teams and our services. We're also
22 very mindful not to overburden them with - you know,
23 they're not the be all and end all for every Aboriginal
24 person that presents into the services. Our goal is to
25 actually get them to upskill us so that we are able to
26 actually work with First Nations communities and consumers
27 as they come through to see us or as we go to see them,
28 which is what we've learned from our Aboriginal trainees,
29 you know, it's much better for us to go to their community
30 rather than them come to our hospital environments.
31
32 So I think it's been an incredible investment and we
33 have been one of the privileged LHDs that are actually able
34 to successfully graduate trainees as well.
35
36 So the attrition rate is quite high. They do come in
37 and they are - usually, you know, they've left school,
38 university isn't what they ever had in mind, so being able
39 to support them to understand, you know, the concepts
40 behind not just assessments and knowing when to hand things
41 in but also navigating a very complex clinical system has
42 been something that we've put - we've invested a lot in,
43 and I think Warren was alluding to one of those investments
44 who has recently left and gone to an executive level
45 somewhere else - the support that she supplied to those
46 trainees was the reason why a lot of them actually stayed
47 and graduated and then stayed within our workforce. So

1 we're now going to try and replicate that model with having
2 a clinical leader in each of our hubs to be able to support
3 and maintain those trainees as they navigate what is
4 usually a very complicated system for them, but if we can
5 support them enough, then they stay and, like I said, we're
6 one of the LHDs that are successful in retaining at least
7 25 per cent of those graduates, which to me is incredible,
8 and it only makes our work space much better for it.
9
10 But yes, I think there is still room for improvement,
11 there's always going to be room to improve, but I think the
12 trainee program as it stands is really, really important,
13 and it does provide them the opportunity to come out and
14 work within existing community mental health services and
15 as equals to the nurses or allied health clinicians that
16 work within those services.
17
18 DR WATERHOUSE: So they are paid to do the actual work
19 within the facilities and they have some time at university
20 as well?
21
22 MS McFARLANE: Yes. So they have study days. They do
23 everything as you would, but you are actually on the
24 ground, working and learning, and you are supported to do
25 your face-to-face days, so they go and do their - like
26 their entire placement is with us, but they do go to uni
27 and they do, like, their two weeks where - whatever it is
28 they are doing there for their actual course work, but then
29 they have dedicated study days. I think it's every Friday.
30 So once a week they actually get dedicated time to actually
31 sit and do their assessments. And they work with the team,
32 so they will have a mentor within their team, so if they've
33 got a problem with an assessment, they've got somebody they
34 can actually talk to and try and navigate how that works.
35
36 So I think it's a fantastic program. I think the best
37 part about it is that Charles Sturt actually - it's
38 a dedicated mental health degree, and I think that's what
39 we've lost in the profession for nursing and for allied
40 health.
41
42 So one of the things that I've started to try and
43 advocate is that universities actually don't see mental
44 health drug and alcohol as a specialty. So way back in the
45 day when I went through university, I had two semesters
46 that were dedicated to psychiatry and I had a dedicated
47 placement that had to take place within a mental health

1 service, wherever I wanted to, and that's each year for the
2 three years I was there. That's all gone. I think
3 a couple of them - every university does it differently.
4 At our locally based universities, including Charles Sturt,
5 it's like a two-week component now and there's no
6 requirement for a placement at a mental health facility.
7 So we have had to do an enormous amount of work to get NGOs
8 to come - sorry, NGNs, so nurse graduates, to come and
9 actually work within mental health and see it as
10 a specialty that it is.
11
12 So we've done a lot of work in regards to that and
13 developing postgraduate recognition for working in mental
14 health, and we've had to go to universities and actually
15 attract their attention to say, "We're here."
16
17 We're about to embark on a project with Sydney Uni,
18 and that's the third year of a nursing degree, they
19 actually do a 20-week placement at Bloomfield, where there
20 is three days online with their university doing their
21 university lectures, but two days physically in the space
22 working, so that they get that exposure. For us to do
23 that, we've got to provide them with accommodation and that
24 sort of thing, but to me, if we can get those 20 places, at
25 the end of their graduate year, actually picking to work in
26 mental health, then that's something that we can grow our
27 own in and actually expand, and that's where your workforce
28 comes to support those community mental health services
29 going forward.
30
31 DR WATERHOUSE: In the last paragraph of your outline, you
32 refer to your concern that the drug and alcohol service is
33 deficient compared to mental health. Can you just expand
34 on that a little bit, and particularly your concerns about
35 project funding as opposed to recurrent?
36
37 MS McFARLANE: Sure. Like I said, in rural/regional LHDs
38 it's a mental health drug and alcohol program rather than,
39 in metro, you have a dedicated drug and alcohol and
40 a dedicated mental health, so they are completely separate.
41
42 Traditionally, and even up until recent times, funding
43 for drug and alcohol wasn't based on recurrent budgetary
44 negotiations, it was all project based. So whatever was
45 being initiated from the state was a project, so nothing
46 was ever recurrent, it just sort of morphed into, you know,
47 "If it works, then we'll keep it going", type thing.

1
2 So unlike mental health, where there is an actual
3 dedicated budget which is allocated so that we can deliver
4 programs, that's never kind of existed with drug and
5 alcohol. So you're constantly trying to come up with
6 innovative ways or ideas, put it to the ministry to try and
7 get funding, but those fundings are always time limited.
8
9 So it wasn't really until the Ice Inquiry, most
10 recently, that the spotlight on drug and alcohol actually
11 became quite real, and so significant funding was provided.
12 Again, they are still time limited, but it is significant
13 funding rather than little pockets of project funding.
14
15 So I think if that's the way the future's going to go,
16 then that's the investment that needs to happen. Because,
17 like I said, there are people in our districts that we
18 didn't even know had addictions that we've found, that
19 really needed support and the support doesn't exist here.
20 The workforce is very very minimal. I think there is
21 a total of 44 FTE for our entire district for drug and
22 alcohol, which, in the scheme of things, is not sufficient.
23
24 OTP, which is the methadone program - as I said, we've
25 got major gaols that are releasing into communities, and
26 like I said, they've relocated, because wherever they've
27 come from they've been significantly in those areas for
28 a long time, so they relocate and become part of that
29 community. We have to take on that methadone person coming
30 out. So it's consistently growing. But the workforce
31 isn't growing with it. So they are the sorts of, I guess,
32 barriers that we're dealing with: how do we grow
33 a workforce when there is no budget that actually promotes
34 growing that workforce.
35
36 So that whole co-morbid approach, which is what we
37 talk about, people with mental health and drug and alcohol
38 addictions, how do we look after that person with the
39 workforce that we've currently got, when drug and alcohol
40 is a specialty on its own. That needs to be recognised.
41
42 I am a mental health nurse. I've had to learn about
43 drug and alcohol to be able to support that through my
44 career. So that's kind of what my statement was: they
45 need to invest properly with a budget that supports drug
46 and alcohol, just as they do mental health.
47

1 DR WATERHOUSE: You mentioned "OTP". Does that stand for
2 the opioid treatment program?
3
4 MS McFARLANE: Yes.
5
6 DR WATERHOUSE: What are the gaps that you see that arise
7 as a result of only having project funding for programs
8 like this?
9
10 MS McFARLANE: Investment in workforce. That's pretty
11 much the biggest part of it. So our OTP especially, it is
12 a very much medical model, so it has a nursing component
13 and addiction specialists that are within that model to be
14 able to support people that are coming through the door on
15 methadone and, as I said, the numbers have probably doubled
16 but the actual workforce FTE has remained exactly the same.
17 So it hasn't grown anywhere across our district, and
18 I think that's the same across the state.
19
20 DR WATERHOUSE: Dr Kealy-Bateman, I just want to finish
21 off with going back to some of what we started talking
22 about before, which was in relation to your engagement with
23 families.
24
25 DR KEALY-BATEMAN: Yes.
26
27 DR WATERHOUSE: You spoke to us about the discharge plan
28 and discharge summary project that you have done. Can you
29 tell us a little bit about the WANTED project?
30
31 DR KEALY-BATEMAN: Sure. Sure. Look, the WANTED project
32 actually came from a family ask, and I won't go into the
33 details of that, but essentially, the situation was that
34 there wasn't good consultation with a family in an
35 emergency department environment, and we were told very
36 clearly that we could do better, and it caused a lot of
37 reflection and I thought about the design of the study
38 where we could see what we had done in Dubbo in the past
39 and we could think about how could we do it better.
40
41 We thought we would focus on looking at people coming
42 in under the Mental Health Act and how often we could try
43 to contact them, their desired next of kin. I use the term
44 "next of kin", because sometimes people who have mental
45 health and drug and alcohol problems don't necessarily want
46 us to contact their family, because their family have been
47 pretty abrasive to them, but they might want us to contact

1 a friend, so I use the term "next of kin". So we did that,
2 and in three months we found that - because the emergency
3 department's a tighter space; in the inpatient space we can
4 contact next of kin more than 97 per cent of the time, we
5 can find someone that the patient is happy for us to
6 contact.
7
8 In the emergency department space the time is shorter,
9 it's harder to find someone. Someone has to actually
10 answer a phone or be with them. So we found that we could
11 do that about 91 - just under 91 per cent of the time, so
12 I will round it up to 91 per cent. So that was really
13 quite remarkable, because when we looked back in time to
14 three months the previous year, it was actually only
15 67 per cent.
16
17 But there was another really important finding when we
18 looked at all patients and the admission rate: we actually
19 decreased the admission rate, by about 12 per cent, to
20 hospital. In actual fact, when you worked with families
21 and you actually problem-solved with the people presenting
22 in the emergency department, they actually preferred to
23 have their treatment at home. So that was a really, really
24 remarkable finding as well. So not only were we giving
25 people what they actually wanted, we were actually able to
26 find better health solutions that were bespoke and
27 absolutely tailored to them.
28
29 So it wasn't actually that much more work. Yes,
30 people were in the emergency department perhaps a little
31 bit longer while you made a couple of phone calls and you
32 sorted stuff out, but we got better health outcomes. And,
33 working with others, we were able to actually organise
34 better health care and structure it with someone. There
35 was actually probably more guarantee that it was actually
36 going to be enacted and work, because you actually had
37 a support system around the person leaving the emergency
38 department.
39
40 So most people that come in under the Mental Health
41 Act, so if someone writes a schedule under the Mental
42 Health Act directing someone to come to an emergency
43 department - that might be an ambulance officer,
44 a magistrate, a doctor like a GP - two-thirds of those
45 people then leave the emergency department after being
46 assessed. That's not just in Dubbo. There was a big study
47 by Vinay Lakra and others - he's a former president of the

1 College of Psychiatrists - that demonstrated that. That's
2 kind of a general outcome. So it's not specific to Dubbo.
3
4 DR WATERHOUSE: And if I can just clarify, when you say
5 "they leave", that's because the schedule is lifted?
6
7 DR KEALY-BATEMAN: Yes, because the schedule is lifted.
8 So it's really important about how we plan for their care
9 and I don't think it's okay for people to just go - my
10 personal view is, if possible, I don't think it is okay for
11 us to just go, "Well, you can just go back into the ether,
12 unsupported", you know? If someone has gone to the trouble
13 of writing a schedule and being concerned about you, we
14 should try to put some scaffolding, a framework of support
15 that includes people who care about you, around you, and
16 that was where the original complaint and concern came to
17 us, and so we wanted to get some evidence around that.
18
19 But that really intriguing bit of evidence was that,
20 you know, we actually reduced the hospital admission rate
21 as well. No-one objected to us sort of saying "Hold on",
22 you know, I cross my arms and look a little bit, "Hold on,
23 I'm a concerned, caring" - I put my kind of parent mode on
24 then - "I need to find someone to work with you to get you
25 home, because I actually care about you as a person." So
26 again, it's when we personalise what we do as clinicians
27 and say, "This is why we're doing this, it is not that we
28 don't trust you going home but that's what's best practice
29 in terms of health care" - and I actually write about that
30 in the article that we published. People find that
31 acceptable as health care messaging and they come up with
32 someone. They have a think about it, we get them a cup of
33 tea and they come up with someone and we work with them.
34 That's what we found in the study and it was wholly
35 supported by the entire emergency department.
36
37 DR WATERHOUSE: And has that been embedded and continued?
38
39 DR KEALY-BATEMAN: Yes, yes, and MHEC is very supportive
40 of that as well. And we know - again, I talked about
41 pre-mortem thinking before, we know that that is a best
42 practice strategy, when you think about, if the worst thing
43 happened, what do we want to go and find in the notes, that
44 we have worked with others, we've thought this through, and
45 that's what you kind of want for a family member.
46
47 DR WATERHOUSE: In terms of consent to share information,

1 is that managed because they, themselves, are identifying
2 the person they want to have contacted?
3
4 DR KEALY-BATEMAN: Yes, and people don't need to be
5 present for every part of the conversation. So if I want
6 to talk about something - and nearly all of our clinicians
7 know that; I'd be surprised if anyone doesn't - there might
8 be something really sensitive that you want to talk about
9 with someone. You just say, "You don't want me to talk
10 about this with mum", or "I want to have a bit of a yarn
11 with you about this bit, shall we ask mum" - or dad or your
12 friend - "to step outside?" You know, you don't ask about
13 sensitive things, for example, like intravenous drug use in
14 front of people. Our clinicians are sensible. They've
15 been trained, they are personable, so we make sure that we
16 get stuff right when we're working with people.
17
18 DR WATERHOUSE: For the record, I'll just read out the
19 number of the article that Dr Kealy-Bateman mentioned.
20 It's [MOH.9999.1273.0001]. I have no further questions,
21 Commissioner.
22
23 THE COMMISSIONER: Mr Cheney, do you have any questions?
24
25 MR CHENEY: No questions, Commissioner.
26
27 THE COMMISSIONER: Thank you both for coming. We're very
28 grateful for your time and you are excused.
29
30 **<THE WITNESSES WITHDREW**
31
32 DR WATERHOUSE: Commissioner, one of the witnesses we were
33 anticipating for today isn't available, so we will able to
34 adjourn until 2.
35
36 THE COMMISSIONER: All right. We'll adjourn until
37 2 o'clock. Thank you.
38
39 **LUNCHEON ADJOURNMENT**
40
41 THE COMMISSIONER: All right, are we ready to resume? Go
42 ahead.
43
44 MR MUSTON: I call Professor Mark Arnold.
45
46
47

1 **<MARK ARNOLD, affirmed: [2pm]**
2
3 **<EXAMINATION BY MR MUSTON:**
4
5 MR MUSTON: Q. Would you state your full name for the
6 record, please?
7 A. Mark Anderson Arnold.
8
9 Q. You are the chief medical officer for the Western
10 New South Wales Local Health District?
11 A. That's correct.
12
13 Q. Which I think is a role you have held since January
14 2022?
15 A. Correct.
16
17 Q. Have you --
18 A. Sorry, did you say - January 2023, that should be.
19 That's a typo.
20
21 Q. So January 2023.
22 A. 2023, yes.
23
24 Q. That brings me to my next question, which is you have
25 prepared an outline of evidence to assist the Commission
26 with its work.
27 A. Yes. Yes.
28
29 Q. You have had an opportunity to read and consider it?
30 A. Yes, yes.
31
32 Q. Other than the typo that we've just collectively
33 picked up in paragraph 2, are you otherwise satisfied that
34 it is true and correct to the best of your knowledge?
35 A. Yes, I am.
36
37 MR MUSTON: That document will form part of the bulk
38 tender in due course.
39
40 THE COMMISSIONER: Yes.
41
42 MR MUSTON: Q. You have held the role of chief medical
43 officer since January 2023. You also continued to practise
44 as a rheumatologist within the health district?
45 A. That's correct.
46
47 Q. I think you tell us that notionally at an FTE of 0.25?

1 A. That's it.
2
3 Q. Is that delivering clinics within the public system in
4 the local health service?
5 A. It is a mixed practice. It's principally private
6 practice and also public clinics, but solely within the
7 local health district.
8
9 Q. I think you tell us that you previously held the role
10 of the head of school of the University of Sydney's School
11 of Rural Health, based in Dubbo and Orange, for around 10
12 years?
13 A. That's correct, yes.
14
15 Q. Was that a full-time position, or was it again
16 a fractional position?
17 A. No, that was a full-time position.
18
19 Q. Other than your role - your current role and the 10
20 years you have spent in that role, have you had any other
21 positions within the LHD prior to your current role?
22 A. So prior to my current role, I was a visiting medical
23 officer and in fact my current role of employment is as
24 a visiting medical officer.
25
26 Q. In paragraph 8 of your statement, if I could ask you
27 to turn to that --
28
29 THE COMMISSIONER: Just before you go there.
30
31 Q. Can I just ask, you have said in your statement that
32 your position as chief medical officer for the LHD replaced
33 the position of executive director of medical services
34 role. Was it just a name change, or was there a new
35 strategy behind the role you currently have?
36 A. Yeah, that's an important distinction, because the
37 executive director of medical services would normally be
38 fundamentally involved with rostering across the whole
39 district and also with significant aspects of workforce
40 hiring, onboarding so on and so forth, but my role is
41 largely strategic. Those areas are dealt with by other
42 directorates in the district.
43
44 Q. What was the thinking behind the creation of chief
45 medical officer, as far as you know?
46 A. The thinking was really to change the culture of
47 medicine and how medicine relates to other health

1 professions within the district. So it's important that we
2 practice to appropriate clinical standards and also that
3 we're actually able to function in multidisciplinary teams,
4 and my role was to try and facilitate those aspects of care
5 which are priorities for the district.
6
7 MR MUSTON: Q. I might come back to that in a moment,
8 but could I ask you to turn to paragraph 8 on page 1, where
9 you tell us about the involvement you have in the
10 assessment of standards of practice and the like. Could
11 you just tell us in a slightly more practical sense what
12 that involves in terms of things you might do on
13 a day-to-day basis?
14 A. So the district has a particular emphasis on all of
15 its clinicians being able to interact with one another and
16 with patients in the most appropriate manner. So that's to
17 do with generally professionalism within the professions.
18 I won't enlarge on the concept of professionalism because
19 it is, you know, quite a broad area, but it encompasses
20 aspects of not only appropriate delivery of clinical care,
21 so competency, as it were, but also how one conducts
22 oneself.
23
24 So the role that I have would also - would look at
25 when we're having issues with a particular doctor who maybe
26 is having some trouble interacting with colleagues and we -
27 I might be asked to intervene and be an arbiter of how that
28 doctor's actually undertaking their conduct.
29
30 Q. Is this a precursor to the complaints process that you
31 refer to towards the end of the paragraph?
32 A. Sure. So the management of clinician complaints and
33 concerns about clinicians is a formalised process in
34 NSW Health, and in big organisations, and I'm sure it
35 happens in the law as it does in medicine, often there are
36 aspects of care that are delivered that could be delivered
37 in a better way, and when there are aspects of care that
38 can be improved with a conversation with a colleague about
39 how one might change one's interaction with other medical
40 professionals or allied health professionals or even,
41 indeed, with patients, it's often a conversation that can
42 actually change someone's behaviour and then lead to
43 resolution of a problem that would not then need to be
44 formally managed.
45
46 Q. Have you found that preemptive strike approach, at
47 least to the extend that you have been involved with it,

1 has been reasonably effective?
2 A. It has been. My background is in also medical
3 education and really we will find that there is a number of
4 people who, when it's explained to them that they are - the
5 way that they are interacting with their colleagues is
6 suboptimal, they will immediately self-correct. They will
7 say "Gee, I wasn't aware of that." There would be a number
8 of people who don't and there will be a number of people
9 who disagree with that assessment. But pointing out these
10 sorts of improvements in care helps teams and it helps
11 patient care.
12
13 Q. Can I come back to your current role, which you tell
14 us is more focused on strategic oversight, leadership and
15 shaping the direction of the medical workforce rather than
16 the mechanics of rostering and the like. When you talk
17 about the medical workforce within the LHD, that, I assume,
18 includes those members of the workforce who deliver acute
19 care in hospitals and hospital-like facilities across the
20 LHD?
21 A. That's correct.
22
23 Q. Does it extend to the delivery of specialist care by
24 clinicians operating within the LHD, either as VMOs or
25 staff specialists?
26 A. Yes, that's correct.
27
28 Q. Do you see that workforce role as extending to
29 strategic planning around the delivery of specialist care
30 in non-hospital based settings, so in private rooms across
31 the LHD?
32 A. Well, the LHD has some input into primary care in the
33 district, as you know, with MPSs and how care is delivered
34 there with GP VMOs, but as far as a direct interaction with
35 people in purely private practice, that - I wouldn't step
36 into that area there. If we were talking about how
37 organisations would relate to organisations, well, that may
38 be an area where I would be involved, but at an individual
39 level, no.
40
41 Q. We might come back to it in a little bit more detail
42 shortly, but in terms of the availability of specialist
43 care in a private setting within, say, a specialist's
44 rooms, is that something which is taken into account as
45 part of the strategic planning that you do from an LHD
46 perspective?
47 A. Yeah, again, there are aspects of this which aren't

1 really within my portfolio, but I can comment on the
2 aspects that are. It's often very difficult to be sure who
3 is delivering private care in anyone's LHD, whether it be
4 ours or another in New South Wales. There are a number of
5 fly in, fly out practitioners who have relationships with
6 the area or relationships with other clinicians, and they
7 may deliver services which can be face-to-face or
8 telehealth. We don't have oversight of that, and that also
9 becomes then difficult in working out how we can plan for
10 service delivery. So, then, service delivery has to take
11 some account of what services are provided in the private,
12 but as we have no control over those, it's rather
13 difficult, then, to actually incorporate them into any
14 strategic decisions about workforce.
15
16 Q. We might come back to that because I'm interested in
17 engaging with you in relation to that strategic service
18 planning. But before we do, in terms of the workforce, or
19 the medical workforce, that you have within your remit,
20 does it include deliverers of primary care, as you see it?
21 A. Well, delivery of primary care insofar as it would
22 occur in our rural sectors.
23
24 Q. By the LHD, or more generally?
25 A. By the LHD.
26
27 Q. So let's turn to the service planning. At
28 a structural level, how does the service planning happen?
29 It starts presumably with the preparation of a service plan
30 document of some sort. If you could talk us through that
31 process of --
32 A. I can talk to you in generalities, but of course
33 service delivery is really involved in the construction of
34 that sort of plan.
35
36 Q. So the plan we're talking about, I should probably
37 ask, does that have a particular horizon? Is it
38 a five-year plan or a 10-year plan?
39 A. Well, in general, the plan is a longer term than five
40 years. A 10-year plan is really what we are looking at,
41 particularly in some of our smaller towns, where we have to
42 look at the demographic trends in those towns and the
43 current needs for service delivery and the projected future
44 needs.
45
46 Q. And is there a formal planning document that is
47 produced for each town?

1 A. I would have to defer to my colleagues in service
2 delivery about particular towns.
3
4 Q. And in terms of - perhaps just bringing it back to
5 your strategic oversight and leadership role, from the
6 point - from your perspective, what do you see as the
7 process that gets rolled out for the planning of the
8 delivery of medical services across the LHD within this,
9 say, 10-year horizon?
10 A. Well, the planning for our base hospitals is somewhat
11 different from our planning for some of our smaller
12 facilities, the procedural facilities, and it's different
13 again for the rural sectors, which is the conventional way
14 that we divide these up.
15
16 Q. So this is planning around services delivered at each
17 individual facility, be it a base hospital or an MPS type
18 facility, and is your point that a different planning
19 process is engaged in with respect to each of them?
20 A. I'm finding it difficult to answer the question
21 specifically because, for instance, in a town which has an
22 MPS, there would be considerable interaction with the local
23 stakeholders about the required service delivery at present
24 and in the future and how we can best meet the current and
25 future needs. So that is a different process from
26 engagement at a base hospital.
27
28 Q. I'm happy to explore that process with you in a little
29 bit more detail, but just at a very high structural level,
30 is it the case that the plans that you are talking about
31 are plans that are made in relation to services which are
32 to be delivered at a particular facility? So there might
33 be a planning process that's engaged in for Dubbo base
34 hospital, and then a different planning process that's
35 engaged in for, say, Coonamble MPS, et cetera? Is that --
36 A. Correct, with the oversight that we need to consider
37 how we actually have an equitable distribution of service
38 delivery across the whole district for all of our
39 population.
40
41 Q. Which brings me to my next question. Is there an
42 umbrella planning exercise that is engaged in that looks at
43 all of the services which are required throughout the
44 district and makes an assessment and plan as to the way in
45 which those services are going to be delivered?
46 A. Yes. For instance --
47

1 Q. What's that process?
2 A. For instance, I can probably best illustrate it with
3 an example. If we wish to build up a particular service in
4 a particular town, we need to think about how that would -
5 that town, having that concentration of services, would be
6 able to actually provide service across the district. So,
7 for instance, if we're planning for cardiology, we need to
8 think about how that will actually relate to the flow of
9 patients from the north and west of our area, as well as
10 the south of our area, to our two cardiology hubs. So it's
11 a district approach that informs how those particular
12 services will be built up in each of those two facilities.
13
14 Q. So I accept that that's the way that it might be -
15 that the planning might be done in terms of what one should
16 strive for, but what I'm asking you, perhaps as
17 a preliminary question, is what is the practical nuts and
18 bolts process by which that planning occurs?
19 A. So there is a process of ascertaining what services
20 are required.
21
22 Q. Let's start with that. How do you go about doing
23 that?
24 A. This is not my directorate.
25
26 Q. Whose directorate is that?
27 A. This is service delivery, as I mentioned.
28
29 Q. So service delivery makes an assessment of what is
30 required. At what point do you come into the process? Is
31 it - do you come into the process as part of the planning
32 around how it is going to be delivered, or is it at some
33 stage after that?
34 A. Well, no, because the - if we're actually looking at
35 what - how we deliver those services, that is a particular
36 job of work for the service delivery directorate. Where
37 I would come in, into the process, is when we're actually
38 at the stage of actually appointing a staff specialist or
39 appointing people through our medical and dental
40 appointments process. I have involvement there, and
41 I might be involved in the interview process.
42
43 Q. So just to understand where your group fits into it,
44 service delivery makes an assessment of the overall health
45 needs of the population, and we can inquire with them how
46 they do that?
47 A. Yes, and informed by our health intelligence unit. So

1 this is how the background information is actually
2 ascertained, and then a plan, a service plan can be made on
3 the basis of what is required to be delivered now and in
4 the future, in the short and long-term horizon.
5
6 Q. And the service delivery will then come up with a plan
7 as to how it is they feel those particular health needs are
8 going to be met by the LHD to the extent they need to be,
9 and then you get brought into the process where it comes to
10 identifying how it is they would be able to fill the
11 positions, the medical positions, that need to be filled in
12 order to deliver on that plan; is that --
13 A. That's broadly correct.
14
15 Q. Could I ask you to turn over to paragraph 11 of your
16 statement, or your outline, I should say. You tell us in
17 that paragraph about the workforce maldistribution between
18 metropolitan and regional LHDs, which we've heard a lot
19 about in our travels, but you do tell us that your LHD has
20 been quite successful in its recruitment of high-quality
21 clinicians to your area. Can I ask, how have you achieved
22 that?
23 A. It's been achieved through normal recruitment
24 processes, but in fact, in attracting people to an area,
25 there's often a word of mouth approach that can be had, or
26 people can be identified as someone who would be
27 a high-quality applicant for an appointment in our
28 district.
29
30 So we have a series of training registrars who will
31 come through in a number of disciplines and, often, if
32 those people are of high quality and are people who have
33 a commitment to rural health, these are people who would be
34 identified as people we would wish to recruit amongst
35 general recruitment processes when we put an advertisement
36 out for a staff specialist or a VMO position.
37
38 We often find that informal methods of recruitment -
39 as many LHDs do - a tap on the shoulder to notify someone
40 that a job is coming up is something that often is
41 undertaken.
42
43 Q. Is there a sort of structured approach within the LHD
44 to the way in which those informal efforts are made? Do
45 you have a group that sits together and talks about
46 appointments that are on the horizon and discusses who
47 might be tapped on the shoulder or what sort of informal

1 approaches might be worth pursuing?
2 A. This would not necessarily happen at the LHD level; it
3 may actually happen at an interdepartmental level or at
4 a hospital level, but of course any applications and any
5 appointments to our district go through the appropriate
6 screening and appointment process.
7
8 Q. You tell us at the end of that paragraph that,
9 nevertheless, there are some significant gaps in specialist
10 coverage in disciplines within your LHD, for example
11 geriatrics and endocrinology. Is there a process that you
12 have for identifying in a targeted way where those gaps
13 exist?
14 A. Oh, it is very clear where those gaps exist.
15
16 Q. How does it manifest itself clearly?
17 A. In hospitals - in certain hospitals it manifests
18 itself with the absence of a clinician in that discipline.
19
20 Q. What about the extent to which deliverers of primary
21 care might be wanting to refer to particular areas of
22 specialist care and not able to do so because those
23 specialist appointments aren't available or accessible, is
24 there any attempt made to measure that or assess that?
25 A. Well, that can be assessed by actually our waiting
26 lists in outpatients and the local health district
27 undertook a study at the end of 2022 to ascertain that, and
28 we found a number of disciplines did have extensive waiting
29 lists, some of which were rather alarmingly large, and some
30 of which were still bothersome and troublesome.
31
32 Q. This may not be something that your group was directly
33 involved in, but once that study was done and the long
34 waiting times were identified, was there a strategic
35 approach taken to filling the gaps with a view to reducing
36 waiting times in some of those areas?
37 A. Sure, well, in a number of those areas, there are
38 ongoing recruitment efforts, but it is difficult to recruit
39 to positions if applicants don't apply. The application
40 process is not only local, it's often international, and we
41 can of course appoint people internationally, as long as
42 their credentials have comparability and they undergo the
43 appropriate college ratification and sometimes supervision
44 processes.
45
46 Q. In terms of the credentialling of the international
47 graduates, do you find that the colleges are reasonably

1 easy to deal with in that regard, or are there some
2 challenges that you have encountered?
3 A. Look, the colleges are fairly - their criteria for
4 determining suitability and comparability of training
5 would - comparability of training also happens at the level
6 of Ahpra, of course, but college supervision is usually
7 reasonably straightforward. In some instances, some
8 flexibility in the level of supervision is required, so the
9 standard 42 weeks of supervision, which needs to be
10 face-to-face, can - on occasions the colleges have been
11 rather flexible with that and that has been rather helpful
12 to actually have high-quality applicants in the saddle, as
13 it were, and actually be able to fulfil their college
14 requirements.
15
16 Q. I might come back to it shortly when we talk about
17 training, but in terms of that supervision, have you had
18 any experience of the colleges facilitating virtual
19 supervision in circumstances where you might have attracted
20 a specialist, an internationally qualified specialist to
21 fill a gap, and the fact that it is a gap means that there
22 is not a local specialist who can provide the supervision
23 that that internationally qualified --
24 A. Yes, that's an interesting model and one that the
25 colleges - in fact, my college is actively pursuing. We
26 have had instances when, for instance, a sub-specialist, an
27 appointee with a sub-specialty interest would normally need
28 to have two supervisors from that sub-specialty and, for
29 example, a general physician has been able to undertake
30 that. So that has been quite helpful.
31
32 I would not be able to comment directly about whether
33 we have had someone who has been virtually supervised.
34 Total virtual supervision would likely be problematic for
35 many colleges. I can really only speak for mine, which is
36 the College of Physicians.
37
38 Q. From the point of view of yours - we might as well cut
39 straight to it - you have drawn a distinction between
40 virtual supervision and total virtual supervision. Do you
41 see that there is scope for at least a high level of
42 virtual supervision for physicians to enable the physician
43 workforce to potentially be trained locally in
44 circumstances where there aren't on-the-ground supervisors?
45 A. Yeah, look - well, I think there is a number of
46 opportunities that the various colleges could entertain.
47 It would probably be necessary to make sure that there was

1 at least one formal supervisor on site and, again, our
2 network arrangements in New South Wales would actually lend
3 itself to that very nicely. However, that's something that
4 college accreditation committees would need to discuss.
5
6 Q. From your own perspective, as someone who has been
7 involved in training for a significant period, where do you
8 see the line might sensibly be drawn in terms of that
9 divide between what can be done virtually, quite
10 effectively, and what really does require a little bit of
11 face-to-face in the room at the same time, as in a physical
12 sense, with a supervisor?
13 A. Well, look, I think it's very discipline dependent.
14 If one is a proceduralist, so if one is a surgeon, I think
15 supervision would likely need to be face-to-face and --
16
17 Q. For a physician?
18 A. For a physician, it would depend on the unit. It
19 would depend on the sub-specialty, and it would likely
20 depend on the trainee as well, how far along on their
21 training journey they were.
22
23 Q. From the point of view of using vocational training
24 opportunities to assist in dealing with some of your
25 workforce problems, do you see that a virtual supervision
26 model, to the extent one can reasonably be accommodated,
27 would be a positive development?
28 A. Look, I think it's - I think it's an option that
29 should be considered and - further to that, you know,
30 I couldn't comment. My personal view, it could be
31 considered. I would defer to the colleges on their
32 decisions about whether that was appropriate for
33 a particular sub-specialty, whether it's a cognitive
34 sub-specialty, whether it's a - or whether it's
35 a procedural sub-specialty.
36
37 Q. Let me ask you to assume that, for the purposes of
38 this question only, there may be some areas in which it
39 could be facilitated effectively so as to produce adequate
40 training. Assume that that's right. It may or may not be,
41 but for the purposes of this question, assume it is. Do
42 you think from your perspective within the LHD that that
43 would enhance your ability to deal with workforce
44 challenges that you face locally?
45 A. Well, it certainly would, because the problem we do
46 have is having the appropriate number of supervisors, and
47 in fact, we've had this in my discipline, rheumatology, and

1 fortunately we've been able to attract an advanced trainee,
2 because we had two supervisors who were college accredited.
3 We had discussed hybrid models of supervision with virtual
4 supervision and a trainee perhaps going back to a networked
5 hospital, but again, that was negotiated with the relevant
6 advanced training committee, but the simple answer to the
7 question, would it enhance our supervisory capacity? Yes.
8
9 Q. And I take it from that, if your supervisory capacity
10 was enhanced, your ability to use vocational training
11 within your LHD as a potential means of filling gaps in the
12 immediate but also potentially longer term in your
13 workforce would similarly be enhanced?
14 A. Yes, there's been an experience across all of our
15 hospitals that people who have spent a year or an extended
16 time training in a rural location will often return - not
17 always, but the longer we have people embedded in a rural
18 location, the higher likelihood there is of retention, and
19 we know that from the medical student workforce data for
20 decades.
21
22 Q. You tell us in paragraph 12 about the part of your
23 role that includes engagement with universities, and you
24 identify the University of Sydney, Western Sydney and
25 Western Sydney Charles Stuart collaboration. In relation
26 to the second two, so Western Sydney and Western Sydney
27 Charles Sturt, have those programs been running for long
28 enough to produce a graduate cohort yet?
29 A. In those instances, Western Sydney University has been
30 established for many years. They have a track record of
31 graduates back a couple of decades.
32
33 Q. Within their rural program?
34 A. Their rural program I would not be able to tell you
35 how long that has been operational for but it's at least 10
36 years. So, again, that's a mature program, so they would
37 have their retention data.
38
39 The Charles Sturt program was only recently
40 implemented. They will have their first graduates in 2026.
41
42 Q. So of University of Sydney and the University of
43 Western Sydney that have had slightly longer running
44 programs, do you have any sense of whether those rural,
45 end-to-end training programs are actually effective in
46 delivering a medical workforce to areas like yours?
47 A. I can speak from the University of Sydney perspective

1 that their cohort roughly 14 per cent will work rurally,
2 who have attended one of the rural training schools, and
3 their graduates go to Broken Hill and Lismore as well as
4 Dubbo and Orange, and that's a mature program. That's been
5 in operation for more than 20 years.
6
7 Western Sydney has the disadvantage that their
8 students can't undertake an internship at Bathurst hospital
9 because Bathurst does not have rural preferential
10 internships. Were they to have those, we know from
11 discussions with their students and their academics that
12 they would be able to certainly recruit people to stay in
13 Bathurst long term.
14
15 Q. When you talk about the internships, that's the JMO
16 positions years 1 and 2 after graduation?
17 A. Yes. In our nomenclature, internships is JMO year 1,
18 and the first resident year is JMO2, or RMOs.
19
20 Q. From your perspective, say at Sydney University, have
21 you, at an anecdotal level at least, seen students who have
22 gone through that program during the 10 years that you were
23 there who have stayed and continue to form part of the
24 medical workforce in the Western NSW LHD?
25 A. Oh, absolutely. So there are a number of senior
26 appointments at Orange who have been through the program
27 and other people who have been through the program at
28 Dubbo, not only in the hospital but also in general
29 practice. There are a number of people out in private
30 practice as well - dermatology, to name a few; a number of
31 FACEMs - Fellows of the Australian College of Emergency
32 Medicine - and anaesthetists.
33
34 Q. I think you tell us that you also have some
35 involvement in student placements within the LHD for
36 students who are currently going through the courses
37 offered by those three universities?
38 A. Yeah, that role - well, without a large side bar to
39 the conversation, universities require general practice
40 placements across the country - all universities - and
41 there are an enormous number of students who are going
42 across various jurisdictions during general practice
43 placements. That's something that's left to the
44 universities to sort out amongst themselves, because we
45 really don't have coverage of that. Where we do have
46 coverage is where we have students who are actually
47 training in our facilities, and so with the implementation

1 of the CSU program and also Western Sydney, it is important
2 to make sure that the programs don't trip one another up,
3 so that they understand when certain universities have
4 their students doing a particular discipline - they may not
5 be able to put students in in that discipline during this
6 period of time, but it's available in other times, and the
7 issue for CSU is they have a fairly - a diversified
8 placement program, which is not solely in Western New South
9 Wales.
10
11 So again, that creates some - certain difficulties for
12 them, but the universities have certainly worked together
13 to make sure that they are not interfering with the quality
14 of student placements, but from the LHD's perspective, we
15 also need to be sure that the supervisory capacity for
16 clinicians for students doesn't actually compromise
17 delivery of patient care or supervision of JMOs and
18 training registrars. So it's a little complex.
19
20 Q. So what is the role played by the LHD in terms of
21 those student placements?
22 A. We don't direct them, but we simply ask that the
23 universities keep us abreast of who is where, so that we
24 actually can make sure that our clinicians are not
25 overloaded in one particular hospital.
26
27 Q. So presumably the LHD identifies at some point the
28 number of placement spots that it has available and where
29 and when?
30 A. Yes, that - well, that, to an extent, depends on the
31 university's program, and they actually differ from year to
32 year. So it's really at a point in time, do we have
33 supervisory capacity, and would the experience in that
34 discipline be sufficient to guarantee that they met AMC
35 standards for that program.
36
37 Q. So do you think there would be any utility in having
38 a centralised - the LHD having a centralised role in
39 allocating those student placement positions around --
40 A. Well, it would be extra - it would be certainly extra
41 work for us that would be of no clear benefit to our
42 clinicians or the LHD. The arrangements that we have at
43 the moment are working well. The universities cooperate
44 well and we know that our clinicians and, importantly, our
45 patients are not overburdened by medical students. So it
46 would be over engineering the solution - it would be
47 a solution for a problem that presently doesn't exist, and

1 realistically in the future, the size of these programs and
2 the size of our hospitals are relatively well matched, so
3 there's not going to be a large expansion in medical
4 student numbers that would actually cause the LHD any
5 particular concern.
6
7 Q. And is a key to that, at least at the moment, the
8 cooperative collaboration by the three universities when it
9 comes to identifying amongst their collective cohort of
10 students who is going go where and when?
11 A. Yes.
12
13 Q. If there was less collaboration by the universities -
14 and I certainly don't for one moment suggest that that
15 would happen - that would create some greater challenges
16 for the LHD, would it not?
17 A. Well, true, it would, but the likelihood of that
18 happening is remote because of the way the various programs
19 have been structured and the arrangements that some
20 universities have made to accommodate the standing up of
21 other programs.
22
23 Q. You mentioned a moment ago the inability to have JMO1
24 and perhaps 2 students training in Bathurst hospital?
25 A. No, sorry, you said JMO1 and 2 students. They are not
26 students, they are doctors.
27
28 Q. I'm sorry, JMO graduates 1 and 2?
29 A. Well, yes. Bathurst - so Bathurst hospital actually
30 has networked interns that come from Blacktown, and so if
31 a Western Sydney University student wishes to go to
32 Bathurst hospital, they would only do so on rotation, and
33 only if they were in the appropriate hospital. So that,
34 for them, is a major problem.
35
36 Q. What's the structural impediment to them saying "I'm
37 a Western Sydney graduate, I grew up in Bathurst and
38 I actually want to do all of my training - my first year in
39 Bathurst". What is it structurally that prevents them from
40 doing that?
41 A. That would not be - well, the - to accredit those
42 positions requires interaction with HETI, Higher Education
43 Training Institute, so to be able to have rural
44 preferential internships, there is another organisation
45 that actually needs to ratify that placement, and, you
46 know, in the - to fulfil the AMC requirements for
47 experience over the first two years of postgraduate work,

1 there needs to be fairly broad experience, and that could
2 be had at Bathurst, but it would not work for the networked
3 hospital to place their interns out there.
4
5 Q. So do I understand you to be saying if,
6 hypothetically, you had a Bathurst local who graduated from
7 medicine and wanted to do their training at Bathurst
8 hospital as a JMO, from an accreditation point of view,
9 they would be able to get the experience that they need to
10 get through that year at Bathurst hospital?
11 A. We think so. We need to again revisit the application
12 to HETI to actually have the whole intern placement being
13 out of that - based at Bathurst. There has been some
14 change to the structure of the first and second years of
15 training, and so that actually probably does facilitate
16 that.
17
18 Q. To the extent that any particular facet of experience
19 was not available to that JMO in Bathurst, do you feel it
20 could potentially be picked up at another facility within
21 your LHD, say Dubbo?
22 A. You have anticipated some of the thoughts that we've
23 already had.
24
25 Q. And, at the moment, the impediment to that happening
26 as a structural possibility has not been approved by HETI?
27 A. Yes. Well, we have to put an application in for that
28 to happen and that - to date, there has not been another
29 application for that. I understand there had been
30 applications made in the past before my time, which I can't
31 comment on.
32
33 Q. So if we could take you to paragraph 14 of your
34 outline, which is on page 2, you tell us there that you
35 are, as I think you have already alluded to, the contact
36 point for the college accreditations. In paragraph 15 you
37 identify a number of issues with the accreditation and
38 placement process which contribute to the recruitment and
39 retention issues for vocational trainees. What are the
40 issues?
41 A. Well, just firstly to go back, the single contact
42 point for all college accreditation is a relatively new
43 development. So that's something that's a requirement now.
44
45 Q. A positive development, do you think, in terms of
46 dealing with accreditation issues across the LHD?
47 A. No, simply as having a contact - simply for actually

1 managing college accreditation processes, there needs to be
2 someone who is actually - who actually has carriage of
3 what's happening - understanding of what's happening in
4 various hospitals at any particular time.
5
6 Q. My question was, do you think having someone in your
7 role who has that knowledge and is that point of contact
8 for all the colleges rather than just one that they happen
9 to be affiliated with is a positive development in terms of
10 dealing with vocational training issues within the LHD?
11 A. Well, I think it is, because then we can actually not
12 have to reinvent processes each round of accreditation.
13
14 Q. So without someone in your position, how did it used
15 to - how did it work in the old days?
16 A. It was done by the heads of department. It still will
17 be done by heads of department, but in fact, what the
18 requirement has been is for there to be a nominated person
19 that the college will direct all of its correspondence to,
20 and the reason for that is sometimes colleges will direct
21 correspondence to individuals rather than roles and those
22 individuals may have moved on, and this happens in
23 metropolitan LHDs as much as ours. So that's that.
24
25 So the issue is for the accreditation to be directed
26 to a role and then the role, the CMO, would contact the
27 relevant head of department in that hospital that is
28 undergoing accreditation and make sure that milestones are
29 being met. What's the second part --
30
31 Q. That's the first bit. The second part was: in that
32 role you have identified a number of issues which you think
33 contribute to recruitment and retention issues for
34 vocational trainees within your LHD. From the position
35 that you are in, what are the issues that you have
36 identified?
37 A. Well, these are areas that we've sort of covered a
38 little bit in the past with the supervisory capacity. It
39 boils down to supervisory capacity.
40
41 Q. Are there other issues that colleges have raised
42 which - as a basis for not accrediting a position which
43 have caused challenges?
44 A. Correct.
45
46 Q. So can you think of any examples that you have
47 encountered in recent times where you feel that supervisory

1 capacity is available but for some other reason a training
2 position has not been accredited?
3 A. Well, the clear example which may be known to all is
4 that the College of Physicians last year withdrew
5 accreditation for basic physician trainees at Bathurst
6 hospital, in the context of there being adequate manpower
7 for supervision.
8
9 Q. What was the rationale for the withdrawal of the
10 accreditation, the rationale given?
11 A. This is - there are aspects of the communication
12 between the LHD and the hospital and the college which are
13 in confidence, but there were issues that were raised with
14 the culture of the hospital at Bathurst and there were also
15 issues raised from the LHD perspective about process.
16 Subsequent to that - forget "subsequent to that", just
17 recently, there's been a document that has actually been
18 issued by the Medical Board about the way the colleges
19 interact and the processes of interaction of the colleges
20 with LHDs, to be mindful of the effect on patient care, on
21 the various effects that withdrawing or suspending
22 a trainee accreditation has on the hospital, so that's
23 actually in fact an ombudsman's report about those sorts of
24 interactions. So there are aspects of the interaction with
25 the College of Physicians and Bathurst hospital which, with
26 respect, I think remain in confidence.
27
28 Q. Is it a particular challenge that some of the issues
29 which, at least in that instance, have been identified by
30 the college as a reason for withdrawing the accreditation
31 are not easily measurable in any sort of objective or
32 analytical sense? That is to say, concern about the
33 culture of an organisation is very hard - to determine
34 whether or not the culture of an organisation is a problem
35 or not a problem, as opposed to, say, the number of
36 trainees per trainers?
37 A. Correct. I mean, there are objective measurements
38 that can be made, but I'm aware of no validated metric for
39 culture.
40
41 Q. Can I ask you to turn forward to paragraph 17 of your
42 statement where you look at some projections for 2026 and
43 the indication that there are some 70 students in the area
44 who are graduating, but there will only be 30 or so
45 positions available. I assume that the Bathurst hospital
46 situation contributes to that?
47 A. The Bathurst hospital situation in relation to JMOs as

1 distinct from what we were just talking about?
2
3 Q. Yes, perhaps I should be clear. Paragraph 17,
4 I assume you are dealing with JMOs - that is, the 70
5 students who are graduating from rural medical programs,
6 who will be going into their JMO1 year?
7 A. Yes.
8
9 Q. And that's a projection for 2026?
10 A. Yes. So if the number of internships across the
11 district doesn't increase, there will be a number of
12 students who, given - who may not be able to be given the
13 opportunity of fulfilling a rural internship.
14
15 Q. We've dealt with the Bathurst hospital situation.
16 What about Mudgee, Cowra, Forbes, Parkes, as you refer to
17 in paragraph 17? What needs to be done in order to
18 facilitate JMO positions within those hospitals?
19 A. So having JMO positions located in that hospital would
20 be again on rotation from our larger base hospitals. So
21 that would be the way that we would facilitate that. So by
22 having a couple of interns in each of those facilities,
23 what that would do, it would increase our pool of interns
24 across each of our facilities and then, therefore, we'd be
25 able to absorb some of those graduates who wished to work
26 in Western.
27
28 Again, we need to go through the process of
29 accrediting those facilities for rotation - to be an
30 accredited rotation by HETI from our base hospitals, and
31 this is work to be done.
32
33 Q. Do you have any reason to think that those hospitals
34 are not capable of being accredited as a rotation site, at
35 least?
36 A. Look, it's feasible and practical that this would
37 occur. Certainly Mudgee is probably further along the
38 track to be able to be accredited for JMO1 positions.
39
40 Q. Can I ask in relation to Mudgee, is that because
41 Mudgee currently has a workforce of I think five rural
42 generalist/RACGP staff specialists who are providing the
43 core level of care through that hospital both in emergency
44 and acute setting?
45 A. That's correct. So the new accreditation requires
46 general experience in managing acute patients, general
47 experience in managing chronic patients, some

1 peri-operative care, and those components can be met at
2 Mudgee at the moment practically.
3
4 In the other hospitals, again, they are at a lesser
5 stage of development. However, there are medical students
6 from the various universities, particularly CSU, who are
7 out at Parkes and interactions with them indicate that they
8 are valuing their experience. So I would be confident that
9 at least one term, particularly general care of chronic
10 illness, would be able to be fulfilled in those locations.
11
12 Q. Is the more traditional model where care through the
13 hospitals is delivered by a GP VMO who might be spending
14 the bulk of their time in rooms and then coming up to the
15 hospital for emergency presentations or a once-a-day
16 round - how does that mesh in with the accreditation
17 requirements for a JMO rotation position?
18 A. Well, this is why I mentioned that Mudgee is further
19 along the track, because these interns do require
20 one-to-one supervision.
21
22 Q. And do I take it from that that a situation where
23 you've got a GP in town who might come up to deal with an
24 emergency as a VMO or do a once-a-day round for acute
25 admitted patients is not going to be able to provide that
26 one-to-one supervision of a JMO in quite the same way as
27 a staff specialist who is employed in the hospital to
28 deliver that care?
29 A. Again, it is a different way of undertaking
30 supervision, but we, again - we need to work that through
31 with HETI.
32
33 Q. If you had a scenario where, due to a lack of
34 availability of primary care in a particular small
35 community, the LHD had employed a staff specialist within
36 a hospital setting to deal with acute patients, emergency
37 presentations, but otherwise deliver primary care through
38 a clinic-type setting on a salaried basis, both to members
39 of the community and also to any aged care residents who
40 happened to be in the MPS, would that enhance the ability
41 to locate a JMO1 rotation candidate within a hospital
42 setting like that?
43 A. Yes.
44
45 Q. You have told us a little bit already, a few times,
46 about the networks with metropolitan hospitals that you
47 have. First question is: are those networking

1 arrangements enabling your LHD to fill gaps in specialist
2 care which is identified, for example, endocrinology
3 I think is one you have alluded to as a gap?
4 A. The network arrangement really has to do with the
5 linkages between the hospitals so that junior medical staff
6 can rotate out. That's one of the fundamental practical
7 advantages of being involved in the network.
8
9 Q. We might be slightly at cross-purposes, and maybe not,
10 but I understand we've referred to networks such as that
11 that exist between Bathurst hospital and Blacktown, so
12 that's a training network. I understood you earlier to
13 refer to a different type of network that might exist
14 within your LHD, and that is networks between particular
15 departments within your LHD and equivalent departments
16 within metropolitan LHDs, for example, perhaps a network
17 between endocrinologists from RPA and your hospital -
18 that's an example I think that may not exist - but an
19 endocrinologist, say, from Liverpool and a hospital in your
20 LHD. Have I understood you correctly in terms of those two
21 different types of networks?
22 A. So there are networks that really function as a way of
23 actually distributing medical staff from one hospital, one
24 metropolitan hospital to rural and other related hospitals.
25 There are other informal networks or referral networks that
26 relate to historical ways that patients will travel for
27 particular sub-specialties. So, for instance, there are
28 particular referral networks for gynaecological malignancy,
29 for argument's sake. So that may be outside of the
30 metropolitan training hospital network.
31
32 When we're looking at actually obtaining services for
33 a sub-specialty such as dermatology or endocrinology, what
34 our LHD would need to do would be to enter into a service
35 level agreement with a network, whether it's in our network
36 or elsewhere, to provide those services. So, for instance,
37 there is a service level agreement that has provided
38 geriatric services to Dubbo for many years from Concord.
39
40 Q. So dealing with that first type of network that was
41 involved in the movement of workforce, is that the junior
42 medical officer workforce and the staff specialist type
43 workforce, or is it really just the former?
44 A. Junior medical officers, basic trainees and advanced
45 trainees.
46
47 Q. So network arrangements - formal network arrangements

1 exist within the system that enable and facilitate the
2 movement of those trainees through the hospitals across the
3 different LHDs. So the example that we have touched on is
4 Blacktown and Bathurst for example.
5 A. Mmm-hmm.
6
7 Q. That's a formal network that exists. What about in
8 terms of the networks that relate to the delivery of
9 specialist services, which I think you have told us involve
10 entry into a service level agreement of one sort or
11 another, are there any formal structures around that beyond
12 the service level agreement, or is it more an ad hoc
13 arrangement that comes into place when a need is
14 identified, an attempt is then made to enter into a service
15 level agreement with someone out there in the wider system
16 who has a capacity to fill that gap?
17 A. When we're getting into the nitty-gritty of this, this
18 is actually getting into service delivery - the service
19 delivery portfolio.
20
21 Q. Do you have a role in that process, though?
22 A. I would often have some discussions, but the decisions
23 would be made with service delivery and the chief
24 executive.
25
26 Q. So let me just take it back one step in terms of the
27 question. I am not so much interested in the nitty-gritty
28 around whether or not you enter into a service level
29 agreement with one hospital or another, but just as
30 a preliminary question, are you aware of any formal
31 networking arrangements whereby these specialists are
32 delivered from metro areas into a regional LHD like yours,
33 that, whilst it maybe facilitated by a service level
34 agreement, exists before that service level agreement is
35 entered into?
36 A. I think you have phrased the question "the delivery of
37 specialists", which implies that people would actually
38 travel out and undertake services.
39
40 Q. Yes.
41 A. I would not be able to actually identify a specific
42 instance which - that would really be in workforce's -
43 sorry, in service delivery's portfolio.
44
45 Q. In terms of workforce, do you think there might be
46 some benefit in having slightly more formal networking
47 arrangements than currently exist between metropolitan LHDs

1 and rural LHDs, as a consequence of which specialists
2 working in metropolitan LHDs might have, as part of their
3 responsibilities in delivering their jobs, the delivery of
4 services to fill gaps in the regional LHD with which they
5 are affiliated?
6 A. Oh, certainly. I mean, that's a logical arrangement.
7 How that arrangement would need to be facilitated would be,
8 for example, a staff specialist is appointed to a certain
9 fraction, a certain fraction of that fraction - let's say
10 somebody is appointed at 0.8 at Prince Alfred Hospital, 0.8
11 FTE. If that contract were to stipulate 0.2 of that is
12 delivered at Dubbo hospital, that would augment the ability
13 to deliver service and it would also augment the ability to
14 supervise, and if we were thinking about how that would
15 work in outpatient care in particular, that's an excellent
16 way of bolstering the capacity to not only care for our
17 patients and meet that unmet need in outpatients, but also
18 to be able to fulfil the requirement for supervision of
19 trainees in outpatients. I know that many governments,
20 state and Commonwealth, have had many attempts at directing
21 how and where the medical workforce would be able to work
22 and the manner in which they would work, and my
23 understanding - I'm not a constitutional lawyer, but
24 I think that's section 51, and I think that pertains to the
25 Commonwealth rather than the state, so it may be up to the
26 state to determine whether that's a reasonable arrangement.
27
28 Q. Because you would have seen in your role examples of
29 where something which may have had origins in a more ad hoc
30 arrangement has resulted in the delivery of excellent care
31 locally by specialists who might be predominantly based in
32 metropolitan hospitals, would you not?
33 A. Sure. We wouldn't really want to dismantle those or
34 attempt to structurally change things that are working
35 well. There is a tendency, of course, to try to
36 re-engineer many things, but when things are working well,
37 I think they are working well. But we want to augment
38 service rather than change it.
39
40 Q. We had an opportunity to view Dubbo hospital last
41 week, and the cancer services there seem - I think they
42 were described as world class and being delivered by
43 a collaboration between some clinicians --
44 A. North Sydney.
45
46 Q. -- based in North Sydney.
47 A. North Shore.

1
2 Q. Coming to your LHD. A more formal arrangement whereby
3 that happened not just because a world class doctor in
4 North Sydney thought it would be a good idea could only
5 assist in terms of facilitating better workforce solutions
6 in regional LHDs?
7 A. No, that's a very structured arrangement, but another
8 arrangement we could give as an example is that Dubbo's
9 orthopaedic service is largely delivered by the orthopaedic
10 service of North Shore hospital as well, and that's again
11 been an arrangement that has been around for 20 years and
12 has worked brilliantly.
13
14 Q. I assume that that arrangement did not come about
15 because there was a formal network between those to
16 hospitals which in some way facilitated or required it to
17 occur?
18 A. I can't - I know it's based on individuals, but
19 I can't speak for arrangements that were made 20-odd years
20 ago.
21
22 Q. Could I ask you to turn over to paragraph 24 of your
23 statement. I just want to - there is a quite a few
24 concepts that are embodied in that and I wouldn't mind
25 breaking them down with you, if that's okay. So we're
26 dealing with outpatient clinics. Starting just as
27 a definitional matter, when you refer to outpatient
28 clinics, am I to assume that it refers to public specialist
29 care delivered in an outpatient setting by a hospital?
30 A. Correct.
31
32 Q. So some of us have had experience of it, and you might
33 turn up to a hospital with a child with a broken bone and
34 then, having had it plastered up, or fibreglassed up, you
35 then get referred to the fracture clinic and you go back as
36 a public patient three or four times to see the specialist
37 who deals with the situation until the plaster gets cut
38 off. That's the nature of the clinic you are talking
39 about?
40 A. Yeah. The other example would be someone has
41 a cardiological problem, for argument's sake, a leaking
42 valve, and they need to be assessed and they would be seen
43 by a cardiologist in an outpatient clinic and perhaps
44 directed towards having a procedure to assess the viability
45 of the valve, whether it needs to be replaced or could be
46 dealt with medically.
47

1 Q. Or perhaps endocrinology, if someone is labouring
2 under a burden of diabetes, ordinarily well managed by
3 their primary carer but reaches a point where it's dropped
4 out of equilibrium in some way and requires some specialist
5 attention, an ability to refer a patient into a clinic like
6 that to get things back on track would be the sort of
7 clinic that you would have in mind when you are talking
8 about outpatient clinics in that paragraph?
9 A. Yes.
10
11 Q. You then tell us without properly funded outpatient
12 clinics, there are patients who have been in hospital who
13 are then lost to follow-up following discharge. Can I
14 break that down into two parts? First, what is a properly
15 funded outpatient clinic? What does it look like?
16 A. Well, a properly funded outpatient clinic is one where
17 we have a number of staff specialists in a hospital who
18 actually undertake outpatient work as part of their
19 substantive role, and so all of that work is encompassed
20 within the hospital funding.
21
22 Q. So when you say "properly funded", you mean the LHD
23 devoting sufficient FTE resources to staff that clinic,
24 either by VMOs or staff specialists?
25 A. Properly as distinct from improperly, the implication
26 was not that they are improperly funded.
27
28 Q. "Adequately" might have been a better word?
29 A. Yes, that's right. Yes.
30
31 Q. So the funding source for the outpatient clinic is the
32 LHD?
33 A. (Witness nods).
34
35 Q. Obviously, there is workforce challenges as well. You
36 could fund the positions but you need to have not only
37 a properly or an adequately funded outpatient clinic but
38 you also have to have one that you are able to staff?
39 A. Yes, and if it's not possible to pay staff, then it
40 won't be funded, and I think the point here I was trying to
41 make, not very well, was that the other model of outpatient
42 care is having visiting medical officers providing that,
43 and they would generally provide that on a fee for service
44 basis, either at an hourly rate or with an arrangement with
45 the hospital.
46
47 Q. So I think it's reasonably self-evident, but where you

1 refer to the absence of such clinics resulting in people
2 being lost to follow-up care following discharge, that's
3 a patient who presents, is admitted as an inpatient for an
4 acute period of care, is then discharged, but without the
5 availability of a public clinic doesn't have their care
6 delivered in a continuous and appropriate way?
7 A. So with the example of a person with very complicated
8 diabetes, yes, that would generally mean that that person
9 would go back to primary care and how would that patient be
10 looked after? Well, by their general practitioner and with
11 the best of - in the best scenario, with frequent input
12 from a treating endocrinologist, whether that is a staff
13 endocrinologist at one of our facilities or another
14 endocrinologist they have a relationship with, or they can
15 be referred to privately.
16
17 Q. In the absence of that, and perhaps exacerbated
18 further still if they don't have ready access to primary
19 care at all, the point you make is that re-presentation is
20 the likely end point?
21 A. Yeah, that's a not uncommon scenario.
22
23 Q. So you go on to refer to changes to the model of care
24 used in New South Wales are required for that to occur.
25 What are the changes that you have in mind?
26 A. If it's possible for us to be able to have a greater
27 degree of funds to be able to - let's take outside our
28 staff specialists, but if we are actually able to have
29 funds sufficient to employ visiting medical officers on
30 a fee for service basis to provide clinics, that would
31 expand our ability to provide care for outpatients. But at
32 the moment, that funding is not available.
33
34 Q. A more formal networking arrangement of the type we've
35 already canvassed, let's say, an endocrinologist from
36 a metropolitan hospital, Liverpool, delivering their 0.2
37 FTE as a clinic service in Dubbo hospital - would that be
38 another slight change to the model of care that would
39 facilitate the delivery of those clinics?
40 A. Yep. Yes, that would be - that - I mean, I think the
41 more flexibility that we have, the better, because there is
42 unlikely to be one single solution for every outpatient
43 deficit scenario that we have.
44
45 Q. And the outpatient deficit scenario presumably will
46 also be a dynamic situation. You might have an
47 endocrinologist today who is able to deliver that clinic,

1 but, for family, personal or other reasons, might not be
2 here in a year's time to deliver those clinics, at which
3 point a different solution needs to be found to have that
4 dealt with?
5 A. Yes, definitely.
6
7 Q. You identify as one of the main challenges allocating
8 time for outpatient work as part of the substantive role of
9 staff specialists. What is the time allocation issue
10 there? I can understand conceptually why, in order to run
11 a clinic, one needs to be given time to do it, but what is
12 it about the current allocation that, time allocation, that
13 stops that from occurring as seamlessly as it otherwise
14 might?
15 A. It is the number of roles that staff specialists need
16 to undertake which involve the direct delivery of care,
17 supervision of trainees, administrative duties, other
18 duties where they may be offsite, seconded to do various
19 work. These are busy people.
20
21 Q. I assume, but correct me if I am wrong, that the
22 majority of these other roles and functions that they are
23 performing are important in terms of the delivery of health
24 care, the training of the next generation of doctors and
25 the professional development of the doctors themselves?
26 A. That's correct. Otherwise, they are simply
27 undertaking service delivery and nothing else, which is not
28 the reason to be a staff specialist.
29
30 Q. If that's right, it's not so much the allocation of
31 each individual's time that you are talking about, in the
32 sense of allocating more of their time to delivering
33 clinical services in an outpatient setting and less to,
34 say, training or outreach services but, rather, does it
35 really boil down to more FTE to enable an adequate
36 workforce with a proper divide of their own time between
37 clinical and non-clinical services to provide an outpatient
38 clinic of the type you --
39 A. I think that's a fair analysis.
40
41 Q. Finally, in that paragraph, I just want to explore
42 with you the proposition that there is no capacity for
43 general practitioners or rural generalists to provide the
44 outpatient services in health services in base hospitals
45 without a 19(2) exemption. Could you just expand a little
46 bit on what that involves, why that's a challenge?
47 A. So there is no definite means, to my knowledge - and

1 I may be corrected - that there is a possibility for
2 general practitioners to actually work alongside
3 sub-specialists in our base hospitals, particularly general
4 practitioners with an interest or people who do have
5 a formal qualification in mental health, paediatrics,
6 women's health and so forth, by having these people working
7 alongside our staff specialists and VMOs, that would
8 augment the workforce clearly, but it would also be an
9 important means of upskilling them and allowing them to
10 undertake shared care out in the community with a better
11 community of practice.
12
13 Q. You refer then to the 19(2) exemption, but do I gather
14 what you are saying is there is a funding impediment in
15 terms of accessibility or the availability of Commonwealth
16 funding through the MBS, which is preventing GPs from being
17 involved in the delivery of these outpatient clinics in a
18 way that is - to collaborate with specialists?
19 A. Yeah; that's correct.
20
21 Q. And it's your view, I gather, that if GPs and rural
22 generalists were able to collaborate in and perhaps even
23 take the running on the delivery of some of these
24 outpatient clinics in appropriate circumstances, that the
25 quality of patient care and accessibility of good patient
26 care would be enhanced?
27 A. That's correct, and I didn't in that paragraph mention
28 the role of nurse practitioners to be involved, and this is
29 another area that would - is important to acknowledge the
30 skills of highly trained professionals who can also augment
31 our workforce. For instance, we in rheumatology in Dubbo
32 have - we may have, hopefully, recruited to a nurse
33 practitioner role which will hugely improve our ability to
34 deliver care to some of our rheumatic disease patients.
35
36 Q. Your view is, wherever it comes from, whether it be
37 the Commonwealth or the state, it would be optimal if
38 positions - nurse practitioner positions, rural generalist
39 GPs, specialists in adequate number - should ideally be
40 funded to enable outpatient clinics which are seen as
41 needed to be delivered?
42 A. Yes, definitely.
43
44 Q. Can I ask you very quickly about primary care. You
45 tell us, as many others have, that there is an existing and
46 evolving failure of primary care in your LHD. How is that
47 manifesting itself in your observation as a clinician?

1 A. Okay. You are aware that there is research that
2 suggests there are 41 towns that have the possibility of
3 losing their general practitioner in the very near future.
4 Even in the large towns, it's clear that there is a lot of
5 fragmentation of care, so, for instance, on Monday, with my
6 advanced trainee, we're in my rooms and we're talking to
7 a patient and discussing - well, one of the questions we
8 now have to ask is, "Who is your GP now? Is it still
9 Dr Smith?" "No, Dr Smith moved on six months ago." Looking
10 back through the file, in the last two years I've written
11 to five different GPs. In some peripheral towns I've had
12 sequential discussions about very complex patients with,
13 each three months, a different locum, highly complex
14 patients. It fragments the --
15
16 Q. These are patients with chronic illness --
17 A. Yes.
18
19 Q. -- that requires a good continuity of care, both from
20 you and from a primary care provider.
21 A. Yes, and the difficulty with that is to actually make
22 an appropriate assessment of a patient with numerous
23 complex conditions takes time, and that is often - often
24 GPs undertaking locums in some of our smaller towns are
25 terribly time poor and that's very difficult for them, so
26 that's - they work to the best of their ability, but it's
27 difficult for them to give the optimal care for that
28 patient.
29
30 Q. It might be a question for service delivery, but in
31 terms of those 41 towns that are shortly going to be
32 without any primary care, is an assessment being made of
33 ways in which the LHD might step in to provide that primary
34 care, insofar as you are aware?
35 A. Yes, that's certainly being considered.
36
37 Q. From the point of view of the delivery of care to
38 patients within those communities, having primary care
39 delivered through the LHD is plainly going to be better
40 than not having primary care at all.
41 A. I think - I think the simple answer is yes, but we
42 also have to be cognisant of unintended consequences
43 whenever the LHD does move into a town and start to provide
44 those services. If there are a number of other general
45 practitioners and general practice services in that town,
46 that could actually threaten the viability of those
47 services, so planning with those other practices is

1 crucial, because the unintended consequence is if we lose
2 another general practice in a particular town, we are
3 really struggling.
4
5 Q. So your point being essentially each community needs
6 to be considered independently, having regard to its own
7 particular circumstances. Where there is an existing GP
8 market which is more than adequately meeting the needs of
9 the community, you can walk to the next one?
10 A. Mmm-hmm.
11
12 Q. Where you've got a community that has a GP market but
13 it's at present not really adequate to meet the needs of
14 the community, one needs to make an assessment in
15 collaboration with the existing market as to what might be
16 done to assist and perhaps revive that market in the
17 perfect world to enable the market-based solution to
18 continue to deliver primary care to the community?
19 A. Mmm-hmm.
20
21 Q. And in one of the 41 towns where it seems there's none
22 and no realistic prospect of another one throwing up the
23 shingle, at that point maybe the LHD needs to look at what
24 it needs to do in order to plug those gaps in primary care
25 that's delivered?
26 A. Yes, I think that's again a fair analysis and the old
27 analogy of if you have been to one rural town you've been
28 to one rural town applies to here. We have to have
29 appropriate arrangements for each of our towns.
30
31 Q. To the extent that you are in categories 3 or 2 - that
32 is to say, no care or a level of primary care which is in
33 need of some sort of support and assistance - from
34 a workforce point of view, do you see there might be some
35 potential synergies, both in terms of the delivery of care
36 but also potentially financial synergies, if the LHD was
37 able to step in and deliver that primary care? When I say
38 "synergies", I mean an ability also to enhance the way in
39 which acute care and emergency care is delivered through
40 some of those sites by the LHD?
41 A. In principle, yes.
42
43 Q. It has the potential to reduce reliance on premium
44 workforce like locums in some of these communities that are
45 relying to an increasing degree upon locum cover?
46 A. Yes, in principle, yes.
47

1 Q. In principle, but your point being that delivering it
2 in practice is undoubtedly going to be challenging.
3 A. Yes.
4
5 Q. And it needs to be funded?
6 A. Yes.
7
8 Q. And the funding, again from the point of view of the
9 patients and the clinician, there is probably not a great
10 deal of concern where that funding comes from, whether it's
11 the state or the Commonwealth?
12 A. I think the patient is completely unconcerned where
13 that comes from and actually doesn't understand the
14 artificial distinction between state and Commonwealth
15 funding to primary care versus the hospital base services,
16 nor should they have to understand that. That's --
17
18 Q. And so the ideal world is the need for the care is
19 identified, the means by which it is going to be delivered
20 is formulated, and then the state and the Commonwealth sit
21 down and have a sensible conversation about how the two
22 funding streams are able to be harnessed to deliver it?
23 A. That sounds a good conversation to have.
24
25 Q. Perhaps not unrealistic. The very last question
26 I want to ask you, if you could go to paragraph 27, you
27 tell us about the single employer model. Firstly I want to
28 ask you about the single employer model, at the moment as
29 it is structured, is it intended to be a long-term solution
30 to primary care or is the current trial more an attempt to
31 try and facilitate training opportunities to encourage
32 fellows, once they get their fellowship, to spread out into
33 the existing market-based GP VMO solution?
34 A. Yes, well, it is. I mean, there are a number of these
35 examples that operate across the country. Again, in
36 Murrumbidgee it has - and I think you have heard of them,
37 their model - it's been quite successful, very much
38 underpinned by the efforts of the LHD and being personally
39 driven by their CE. Again, I just recall that, you know
40 one country town, you know one country town.
41
42 In New South Wales, the single employer model has
43 been - well, it's been stood up. The model is variably
44 financially attractive to general practices. For some, it
45 may be acceptable, for some it may not be, and that
46 sometimes relates to the general practice trainee who is
47 working in that facility. So, generally, a more

1 experienced doctor will be able to see more patients of
2 greater complexity and with our model of funding, that's
3 how general practice is remunerated, so for a younger - to
4 take on a younger trainee, that may actually not be
5 financially viable. If that trainee stays with that
6 practice in the longer term, then the balance is achieved.
7 However, there is no guarantee that that trainee may stay
8 in that practice.
9
10 Q. You mention at the end of the paragraph that there is
11 a financial impost on hosting practices, which is perhaps
12 discouraging participation in the single employer model
13 scheme. Could you just explain how that financial impost
14 comes about?
15 A. Well, one of the reasons for staying involved in the
16 hospital service is all one's on-costs - so superannuation,
17 maternity leave, long service leave, sick leave - is
18 covered. It has been difficult to actually ensure that the
19 financial model - that the LHD covers on-costs and its
20 contribution to salary, versus how the earnings of
21 the general practice trainee in the practice will actually
22 work out, and many practices are actually concerned about
23 who actually bears the on-costs, and at the moment it is
24 the LHD.
25
26 The practical conclusion of that is there perhaps has
27 not been the uptake across New South Wales that has been
28 thought. Some of the models of billing that have been
29 proposed have been, to my general practice colleagues,
30 unrealistic, and then there has been some reluctance to
31 actually sign up to this initiative.
32
33 Q. So that initiative is something, just to come back to
34 the categorisation we looked at earlier, which is more in
35 that category 2 market, with an existing population of GPs
36 but perhaps not quite sufficient to meet the needs of their
37 community, and this is a supplement in an attempt to try
38 and kick-start it and create some long-term workforce
39 solutions within private practice?
40 A. It is, that's correct, but again, there's the issue of
41 supervision for that trainee, so that that takes time for
42 the supervising GP, and they are used to this with general
43 practice trainees, but again, the economic model of general
44 practice is very tight, and the time taken and the
45 remuneration recouped sometimes are not favourable.
46
47 Q. Would it be fair to say that the thinner the market of

1 GPs in any particular community, the greater the potential
2 benefits of a single employer model like this, in terms of
3 what it might deliver for that community? So if you have
4 got a particular community that has got a - it's
5 particularly critical in terms of its GP population, the
6 benefits to that community of a single employer model
7 working well are obviously going to be particularly good
8 when compared with, say, a town that's got more GPs?
9 A. Well, particularly if that GP is retained and also
10 when we're thinking about rural generalism, that they can
11 actually provide an advanced service, whether that be
12 anaesthetics, some surgery, paediatrics, at the local
13 facility perhaps with the 19(2) exemption.
14
15 Q. Equally, though, with the impost of supervision and
16 training on the GP who is taking on the single employed
17 trainee, in a particularly thin market that is already very
18 stretched, the ability to deliver that supervision is
19 probably also going to be somewhat reduced; would that be
20 right?
21 A. That's - well, I think that's right. That's why some
22 general practices have taken the position that it would not
23 work for them. Others have decided it may work for them
24 and some have decided it will.
25
26 MR MUSTON: Thank you. I have no further questions for
27 this witness, Commissioner.
28
29 THE COMMISSIONER: Thank you. Mr Cheney?
30
31 MR CHENEY: Nothing, Commissioner.
32
33 THE COMMISSIONER: Thank you very much for your time,
34 Professor. We're very grateful. You are excused.
35
36 **<THE WITNESS WITHDREW**
37
38 THE COMMISSIONER: We might just take a five-minute break
39 before the next witness, so 3.35.
40
41 **SHORT ADJOURNMENT**
42
43 THE COMMISSIONER: All right, we will commence with the
44 next witness, then, thanks.
45
46 MR FRASER: Thank you, Commissioner, I call Maryanne
47 Hawthorn.

1
2 **<MARYANNE LOUISE HAWTHORN, affirmed: [3.57pm]**
3
4 **<EXAMINATION BY MR FRASER:**
5
6 MR FRASER: Q. Could you give your full name, please?
7 A. Yes, it's Maryanne Louise Hawthorn.
8
9 Q. We understand that your title is executive director,
10 strategic reform planning and partnerships within the
11 Western New South Wales Local Health District; is that
12 right?
13 A. That's correct.
14
15 Q. You have been in that role since, I believe, May of
16 2023?
17 A. That's correct.
18
19 Q. And before that, you were, we are told, the director
20 of the health intelligence and planning unit within this
21 local health district?
22 A. Yes, that's right.
23
24 Q. You have prepared an outline of evidence; is that
25 correct?
26 A. Yes, it is.
27
28 Q. Do you have a copy there with you?
29 A. Yes, I do.
30
31 Q. Have you had an opportunity to read through that
32 before giving evidence today?
33 A. Yes, I have.
34
35 Q. Thank you. Is there anything in that outline that,
36 now you have read it again, is incorrect or you would like
37 to change?
38 A. No.
39
40 MR FRASER: That will form part of the bulk tender in due
41 course, Commissioner. The relevant code is
42 [MOH.9999.1196.0001]
43
44 Q. You have set out in your outline the functions and
45 teams that make up your portfolio. At a high level, you
46 have set those out in paragraph 3. Planning, which
47 I understand encompasses strategic specialty and clinical

1 services planning, change management for redevelopment
2 projects; is that right?
3 A. Yes, that's right.
4
5 Q. Health outcomes and evaluation, which involves
6 analysis of population health data, complex data analysis
7 and evaluation; is that right?
8 A. Yes, correct.
9
10 Q. Strategic reform, community engagement, data and
11 information, data integrity and clinical coding, and
12 performance and analysis; is that right?
13 A. Yes, that's correct.
14
15 Q. It would seem to me at least, looking at those
16 different functions, that those functions, to an extent,
17 interrelate; is that right?
18 A. Yes, they do, they complement each other quite well.
19
20 Q. In terms of what you have listed in the first of the
21 items, that is planning, a lot of those other functions
22 feed in to the information - provide the information that
23 enables planning?
24 A. Yes, that's correct.
25
26 Q. Now, in your outline, you have set out several
27 different aspects of planning, which lead to the - one of
28 those, I should say, is the formulation of the strategic
29 plan for the local health district; is that right?
30 A. Yes, that's right.
31
32 Q. The current strategic plan which is for the years 2020
33 to 2025; is that right?
34 A. Yes, that's right.
35
36 Q. So formulated prior to you taking up your current
37 post, but whilst you were in your previous post?
38 A. Yes, correct.
39
40 Q. We will go to it in a moment, but can I ask, the
41 current plan is scheduled to run until next year. How far
42 out do you start the next strategic plan?
43 A. We will start the next strategic plan in the second
44 half of this year.
45
46 Q. So that's a process that's about to begin?
47 A. Yes, so we'll begin later this year.

1
2 Q. And if we might just go to the process of that, can
3 I take you to the current plan. It's E.7 in the tender
4 bundle, code [SCI.0009.0027.0001]. We will have that
5 brought up. If we go to page 13 of that document, and just
6 zoom in on the top part a little, I appreciate this is
7 obviously accurate, presumably, as at the time this plan
8 was published, but there is a diagram that sets out what is
9 termed the "Western NSW LHD planning framework", and
10 obviously there is some, I presume, differences between
11 then and now, for instance, premier's priorities, I believe
12 is something that existed under previous government, it's
13 not something that exists now; is that right?
14 A. Yes, that's my understanding.
15
16 Q. But in terms of the general approach to formulating
17 a strategic plan and then where that feeds into, is it
18 still at least roughly accurate?
19 A. Yeah, this is - it's broadly accurate. We describe
20 this, if you like, like our hierarchy of plans, and so some
21 other things that feed into it. Obviously there is a new
22 state health plan, the Future Health, as well as a regional
23 health plan, that would feed into our next strategic plan.
24
25 Q. Future Health is a strategy and a report, I believe.
26 I think they are already in evidence. The regional health
27 plan, what's the region to which you refer?
28 A. All of regional New South Wales.
29
30 Q. The regional - yes, the regional health strategy, is
31 that --
32 A. Yes, that's probably it. Sorry, I've misnamed it.
33
34 Q. So those sit, to an extent, over the top; they are set
35 not by the district. Just to go to district specific
36 aspects, I'd like to ask you, on the left-hand side of that
37 diagram, not orientated correctly, there is a box that says
38 "Western NSW LHD Health Needs Assessment and Other
39 Commonwealth and State Plans and Priorities". So the other
40 state plans are the regional plans and the state plan.
41 What are the other Commonwealth plans to which that refers?
42 A. Things we might consider there, as we're a large
43 provider of residential aged care services through our
44 MPSs, we might consider any Commonwealth directions around
45 residential aged care and MPSs that are relevant to pick up
46 there. That's probably one of the biggest ones.
47

1 Q. Just in terms of health needs assessments, those are
2 completed at a district level; is that right?
3 A. Yes, they are. So I can probably give you a bit of an
4 explanation of how we do that in Western New South Wales,
5 if that --
6
7 Q. That's precisely what I was about to ask you. Thank
8 you.
9 A. If that's helpful. Our team completes what we call
10 the health of the population report, which is essentially
11 a large component of the health needs assessment. So
12 that's a statistical analysis of a number of data sources
13 that look at the population health metrics for
14 a population, the demographics and some of the disease
15 burden, if you like. We do that on behalf of ourselves as
16 Western New South Wales Local Health District, the Western
17 NSW Primary Health Network and the Far West Local Health
18 District.
19
20 The primary health network then uses that information
21 to complete their health needs assessment. That's
22 a requirement that they need to complete for the
23 Commonwealth every two to three years. They then add to
24 all of that data and analytics that we've done with a phone
25 survey and some other forms of consultation as well to
26 produce that health needs assessment.
27
28 Q. If I could just break that down a little bit to make
29 sure I understand that. The health of the population
30 report which you started with, which is the statistical
31 analysis, is that - that's compiled at a district level?
32 A. Yes, it is.
33
34 Q. Is that by the health intelligence unit, of which you
35 were the director before taking this current position?
36 A. Yes, that is.
37
38 Q. In terms of - and each district does its own; is that
39 right - Far West does a separate one to you, for instance?
40 A. We do it on behalf of Far West.
41
42 Q. That's a shared function?
43 A. Yeah. So the health of the population report for
44 Western New South Wales covers the entire primary health
45 network region, which is both Western New South Wales and
46 Far West Local Health District, and then we break that down
47 into a Western New South Wales summary and a Far West

1 New South Wales summary so that each LHD has something they
2 can use within their local health district.
3
4 Q. In terms of that statistical analysis of data sources,
5 what are the data sources that you are analysing?
6 A. Yes, there is a number of them. They include a lot of
7 population and demographic data, so from the Australian
8 Bureau of Statistics, the Department of Planning and
9 Environment in the population projections for our region.
10 They would include a large proportion of data from
11 HealthStats New South Wales, which is a publicly available
12 data source that the ministry produces, and has information
13 on a variety of health risk factors as well as specific
14 conditions by local government area.
15
16 It will include information from the Australian Early
17 Development Childhood Census, which is a measure of
18 childhood vulnerability across five domains, and it will
19 also include other information from I think it's called
20 HUGO, from memory, which has information around other
21 factors that might influence the health of the population.
22 Usually that's in the social determinants domain.
23
24 Q. So having done that statistical analysis, is it then
25 the case, I think you said, that the actual health needs
26 assessment, as opposed to the backward-looking - well, not
27 backward-looking but retrospective looking statistical
28 analysis - is done by the PHN; is that right?
29 A. No, that - what the PHN usually does is a phone
30 survey, so they will do that of community members, which is
31 essentially a qualitative component, if you like, to add to
32 that, and so that will be about what health issues people
33 see as important and, you know, they may ask some other
34 questions that are essentially complementing that data
35 analysis that we've done.
36
37 Q. So in terms of the actual health needs assessment, who
38 is completing that?
39 A. Well, essentially we both do. Yes. So --
40
41 Q. You prepare separate documents?
42 A. Yes.
43
44 Q. I believe the PHN's one may be publicly available, but
45 can you tell us what yours - the district's - looks like?
46 A. Yes, I can. So it's essentially a quite lengthy
47 report which looks at - outlines the demographics for our

1 region in terms of age profiles, populations by local
2 government area, and then it has a number of chapters, if
3 you like, and those chapters talk about particular health
4 conditions, so it might be cancer incidence, for example;
5 it might be respiratory conditions; it might be diabetes,
6 and the team will do analysis by LGA and they will compare
7 trends over a long period of time for the Western New South
8 Wales region compared to the state average for a number of
9 conditions.
10
11 They might also include in that report other factors
12 around, say, for example, internet access in local
13 government areas, or other things that might influence the
14 way that a community could access health care.
15
16 Q. I will just ask you this. You say at paragraph 25 of
17 your outline that, historically, this assessment was
18 completed every two to three years.
19 A. (Witness nods).
20
21 Q. And now it is updated more regularly. How often is it
22 done?
23 A. So it's done periodically. Because it uses a number
24 of different data sources, they're not necessarily all
25 updated at the same point in time. So we will update the
26 document as new data becomes available. So someone from
27 the team is working on it throughout the year in different
28 time frames, depending on what has become available.
29
30 Q. So is it the case that it may vary - the interval
31 between the updates may vary, depending on what is coming
32 out when?
33 A. Yes.
34
35 Q. When was the most recent health needs assessment of
36 the LHD completed?
37 A. The most recent report I believe was last year, and
38 then we do an update ahead of our annual board planning and
39 executive planning day with anything that we're aware of
40 that might have changed of significance in that period.
41
42 Q. If that was the document we wished to obtain, that
43 would be the most recent - the 2023?
44 A. Yes. We actually moved it into an online environment
45 called Confluence internally so we can update it at points
46 in time, so essentially we would PDF that current version
47 and could provide that.

1
2 Q. Thank you. You have said - so the PHN compiles its
3 own health needs assessment document, which, having had
4 a quick look at it, it's fairly lengthy as well. To what
5 extent does your assessment take into account the things
6 the PHN raises in its assessment?
7 A. Ours is largely the data and analytics component of
8 it. In previous years the PHN has shared the results of
9 their phone survey with us, and then we will use that as an
10 input into planning.
11
12 Q. To what extent - just before we move on to what is
13 then done with the health needs assessment and how one gets
14 from there to the end point of what services actually can
15 be provided and how that feeds into budgeting, et cetera,
16 one of your other functions, or functions of your
17 directorate, is community engagement. You have referred to
18 the PHN's telephone survey.
19 A. (Witness nods).
20
21 Q. But to what extent does community engagement feed in
22 to the assessment of health needs?
23 A. It's probably helpful to talk about health needs
24 assessments in a couple of different ways. So we do
25 a health needs assessment of the general Western New South
26 Wales population. What that really does for you is distil
27 priority health areas for you at a regional level, and as
28 you can appreciate, it is quite a big region, and a number
29 of different communities. There is nuance between those
30 health needs by specific community. So, for example, your
31 cancer incidence or your incidence of COPD might be higher
32 in one local government area than another.
33
34 So we sort of - we have a global view, if you like,
35 which is the health needs assessment for the whole region,
36 and then when we're doing planning, we're generally doing
37 more detailed planning around either a particular
38 catchment, so that might be a hospital or a number of
39 hospitals in a network or a particular specialty, like
40 renal services, for example. To do that, we then use all
41 of that data and information we've done for that LGA from
42 the health needs assessment, so all that statistical data,
43 and then we ask the community. So that adds to it, because
44 when you are doing a planning exercise, it's both the
45 quantitative data that you've got from your statistical
46 analysis, so your analysis of trends, and what the
47 community tells you, that is absolutely critical. So we do

1 that very much at a local level and so we'll often do that
2 by either designing surveys, so we'll ask people what they
3 see as the important health issues in their community;
4 we'll ask them what they think works well, we'll ask them
5 what any service gaps are, we'll do meetings with a number
6 of stakeholders, we might do pop-up stands at shopping
7 centres to try and engage more people. We have run
8 community forums in the past. All of this is designed to
9 complement what we know from the statistical analysis that
10 we've done.
11
12 So your nuance really comes when you are doing that
13 planning at that more local level or that subregional
14 level, if you like, if you are looking at a few services
15 together.
16
17 Q. Can I ask you, in terms of your engagement with groups
18 in that process, who are you engaging with?
19 A. Yes, so if we're doing say a clinical services plan
20 for a facility like Bathurst, for example, which we've done
21 fairly recently, or Cowra or Dubbo, Narromine and
22 Wellington, we'll engage with a number of stakeholders in
23 that community. So that will include the primary health
24 network. We often use the primary health network as
25 a conduit to access GPs, particularly in a larger
26 community, but sometimes in a smaller community we'll just
27 engage directly with the GPs, particularly when there might
28 be only one or two general practices in the town. We'll
29 engage with other service providers in the region and set
30 up consultations with them. We'll engage with the local
31 council, we will engage with the local Aboriginal lands
32 council, with Elders groups, and any other community groups
33 that might exist in the region. There might be, you know,
34 particular - like a cancer advocacy network, there might be
35 other support groups, there might be a local health
36 committee. It really depends on the make-up of what is in
37 that community. But we do our best to try and consult with
38 as many people that might have an interest in the planning
39 work that we're doing as possible.
40
41 Q. I will just raise the issue of GPs. You have said
42 sometimes in the smaller areas or smaller towns, there
43 might be only a few GPs and you will engage with them
44 directly. We've heard some evidence yesterday that for
45 instance in Dubbo there are two practices that provide on
46 an estimation service each about 20 per cent of the
47 community. Do you engage with practices like that when you

1 are planning for Dubbo?
2 A. In Dubbo, I understand that we went through the PHN as
3 the conduit to engage with practices. I believe, because
4 that was part of a plan with Narromine and Wellington as
5 well, I believe we engaged directly with the GPs in
6 Narromine and Wellington.
7
8 Q. Perhaps moving around a little bit here but staying
9 with the topic of GPs, presumably in planning health needs
10 and then onwards to clinical services plans, one of the
11 issues particularly in some of these towns is the viability
12 or endurability of the GP services that are in that town.
13 A. (Witness nods).
14
15 Q. Are they going to be there next year or in two years,
16 for instance.
17 A. (Witness nods).
18
19 Q. How do you go about doing that?
20 A. That does get raised, particularly in smaller
21 communities, but not only in smaller communities. I think,
22 to probably take a step back, traditionally speaking health
23 agencies generally plan for the services that they are
24 responsible for delivering and that has been the
25 traditional approach in Western New South Wales. So when
26 we're doing a clinical services plan, we're generally
27 planning for the services that will be delivered by
28 NSW Health out of that facility or community health centre
29 or visiting services.
30
31 There is a strong interdependency, however, in small
32 communities, between general practice and the hospital. So
33 whether that's - we could do a GP obstetric service or
34 there might be GPs providing anaesthetics or a GP VMO in a
35 smaller hospital, so we will engage.
36
37 We do get questions raised around the viability of
38 primary care or the community will raise concerns around
39 affordability, or if a GP is retiring in the town. That
40 probably did come up, Cowra is probably a good example of
41 where we had that there might be GPs retiring and/or were
42 not able to bulk bill to the rates that they had before and
43 concerns were raised by the GPs around the impact on the
44 emergency department. So that was something we were able
45 to look at in the context of our planning to see that
46 trend, also look at our emergency department presentations
47 and consider whether our projected emergency department was

1 going to be right sized to meet that need.
2
3 Q. Of course, one factor is the impact on changes to
4 primary health care provision in a community on the
5 services, the hospital-based services that NSW Health
6 provides or the district provides?
7 A. Yes.
8
9 Q. Is there also an aspect of consideration of where,
10 such as in the Four T area, there may be a failure,
11 a market failure in relation to the provision of GP
12 services, for instance?
13 A. There hasn't - in the planning exercises we've done so
14 far since my tenure in the role, there hasn't been a sole
15 practice in the situation of the Four Ts, already, you
16 know, at failure point or not going to be viable. We have
17 considered, in some of the smaller communities - Canowindra
18 HealthOne would be an example - collocation of the general
19 practice with the community health, which will be at the
20 hospital, so that is a collocation model that aims for much
21 closer integration of services, and in some of the service
22 planning we've done around Wellington as part of that
23 network plan I mentioned earlier, that's a consideration as
24 well. We would propose a HealthOne model for Wellington.
25
26 Q. Sorry, that's something that you are likely to?
27 A. That's something that, in our clinical services
28 planning, we've identified as a good future direction for
29 the Wellington health service.
30
31 Q. I think we're hearing from a GP from Wellington
32 tomorrow, Dr Spencer.
33 A. Yes.
34
35 Q. Who is, I believe, the last private GP or GP practice
36 in the town.
37 A. Yes, I understand so.
38
39 Q. Can I ask you, just in terms of information and data
40 that GPs may have to offer that might be relevant to
41 planning, do you obtain information from GPs about, for
42 instance, the difficulties or the experiences their
43 patients are having in accessing specialist services, or do
44 you get that information from elsewhere?
45 A. Through consultation we get that. So that would be
46 anecdotal information. The other thing we have looked at
47 recently is the Australian Institute of Health and Welfare

1 publishes MBS data around specialist access by local
2 government area, as well as primary care access by local
3 government area, so that's one of the sources we will
4 consider.
5
6 We'll also look at our own specialist services in
7 terms of activity and volume - this is outpatient clinics
8 I'm referring to here - and obtain information around
9 waiting lists.
10
11 Q. If a patient is referred to a service that isn't
12 accessible in a district, though, and isn't able to travel
13 to get it, that won't be reflected in MBS data, will it,
14 because they just won't be accessing the service anywhere?
15 A. No, it won't.
16
17 Q. So that information you say you get from community
18 consultation?
19 A. That's where your community consultation will come in.
20 So that would be some of the barriers that the community
21 would raise. If there is a particular specialist service
22 they have to travel for and the cost and the difficulty of
23 travel is a barrier to get there, then you may have people
24 who are not accessing care.
25
26 Q. Your large busy GP may also be a good source of that
27 kind of information, would you agree?
28 A. Yes, I would agree.
29
30 Q. Do you get to capture that somehow?
31 A. Probably not as well as we have - we could. I think
32 that's definitely an area for where we can improve our
33 planning and our direct engagement with general practice in
34 the region.
35
36 Q. Just in terms of you also mentioned consulting with
37 your other providers, does that encompass, say, your NGO
38 providers such as, to give an example, Marathon Health, who
39 are an allied health provider in the region?
40 A. Yes, it does.
41
42 Q. At what stage do you engage with them?
43 A. So I believe - so, for example, on the Dubbo Narromine
44 Wellington clinical services plan and the Bathurst clinical
45 services planning process, we met with Marathon Health and
46 I understand they also provided feedback on our draft
47 clinical services plan during that process.

1
2 Q. Is that something that's increased in recent years,
3 the consultation with groups like that?
4 A. I can only comment since I've been in the role.
5
6 Q. Indeed.
7 A. I think one of the things we've tried really hard to
8 do in Western New South Wales is improve our process of
9 planning. Combining some of the functions into a single
10 team obviously assists with that, because we do have
11 community engagement and more data available. But the
12 process of planning is really, really important. Obviously
13 the end result is really important, but the process is just
14 as important, getting the engagement right, making sure you
15 get the right information from people, bringing people -
16 connecting people around what the future vision for the
17 service might be, and learning around emerging evidence and
18 models of care or the way that health care might be
19 changing - we learn that best from the clinicians who work
20 in our services, so that we can ensure our plans reflect
21 all of those things.
22
23 So we've done a lot of work to try to improve the way
24 we do planning and there's always more improvement that we
25 can make of course, but it has been a focus for us over the
26 last five years.
27
28 Q. I think you said combining those teams into one
29 directorate. Is that something - were they previously
30 separate, were they?
31 A. Yes, they were.
32
33 Q. And when did they combine?
34 A. So planning was combined with health intelligence unit
35 around 2019, and then we had a community engagement
36 function come over to the team and then, most recently, the
37 strategic reform team has been established, which was
38 a realignment of some other parts of the organisation to
39 form our larger directorate.
40
41 Q. Just to come back to the process, your health needs
42 assessment is at this regional level and the next stage is
43 clinical services plans; is that correct?
44 A. Yes.
45
46 Q. Sorry.
47 A. Yes.

1
2 Q. The clinical services plan, is that effectively the
3 next level of the process?
4 A. Yes. So your health needs assessment informs your
5 strategic plan for the organisation because that is that
6 regional level, and it will give you quite a strong lead on
7 the health priorities for your community. It will also
8 inform your clinical services framework which sits
9 underneath your strategic plan and then the local
10 government data that's included in the health needs
11 assessment informs your clinical services plan, or your
12 specialty plan which might be, for example, a renal plan or
13 a cancer plan.
14
15 Q. And are they on periodic reviews in the same cycle as
16 the strategic plans?
17 A. Generally the life span of a clinical services plan is
18 around 10 years, so you will have different clinical
19 services plans at different times. In a district like ours
20 where you have 38 facilities, and quite a small planning
21 resource, you are always working on a clinical services
22 plan of some sort. They are not ever on the same cycle
23 where they are all done on a certain year.
24
25 Q. I see. I think you referred to the framework,
26 clinical services framework.
27 A. Yes.
28
29 Q. We understand the current framework is 2020 to 2025.
30 A. (Witness nods).
31
32 Q. That informs the plans; is that right?
33 A. Yes, it does.
34
35 Q. Can I just ask you this: in terms of this overall
36 process of planning, does it ever reach the position that,
37 sort of standing can back from it, there is an assessment
38 of exactly what is needed and then an assessment of what
39 all the different health providers can provide and then
40 looking at which parts are going to be provided by whom?
41 A. Mmm.
42
43 Q. And thinking "There's a gap", "They can't be provided
44 by anyone else", "It's a need for the community, maybe the
45 district might need to step in and fill that gap"?
46 A. (Witness nods).
47

1 Q. Is that achieved or --
2 A. I think that would be an ideal model. In reality,
3 I think what you have is, with our state/Commonwealth
4 health system, you do have agencies that generally plan for
5 services they have the remit for. Now, in the process of
6 planning, we will identify information around gaps in
7 service or particular needs. Sometimes it might be
8 appropriate for service development for the health district
9 to step into that space, or it may be information that is
10 more very much in the primary care domain, and sometimes we
11 might pass that on to another organisation.
12
13 However, I think there is an opportunity in the
14 future, what this often means is you have a lot of
15 disparate planning happening by different agencies, because
16 there is - there are different drivers, there are different
17 funding sources, there are new programs that come out that
18 will mean you need to undertake a planning process for that
19 as well as our own drivers. All the drivers of these
20 organisations might not be the same and they might not line
21 up perfectly at the same time. So we may have demand
22 pressures that mean we need to do some clinical services
23 planning in Bathurst, for example, but that might not
24 necessarily be the priority of other agencies in the region
25 at the same time.
26
27 So it's an excellent concept in theory, and I strongly
28 agree that that would be fantastic, and I think that's
29 a shared principle in the health reform agreements, and all
30 agencies would agree that joined-up planning is a great
31 thing to aspire for. The reality is, it doesn't always
32 happen in that way, despite best intentions.
33
34 So I do think that is an opportunity to think about
35 that. It does require an agency to have a planning
36 leadership role, and a recognised planning leadership role
37 and legitimacy in that.
38
39 Q. That's a role that you hold in the district?
40 A. For our services, yes.
41
42 Q. For your services.
43 A. Yes.
44
45 Q. Looking at other significant organisations in the
46 district, the PHN would be another?
47 A. Yes, the PHN would be another.

1
2 Q. And --
3 A. The Rural Doctors Network with be another.
4
5 Q. Thank you, the Rural Doctors Network. Is there ever
6 a time - are there any other large - significant -
7 organisations?
8 A. There are other large significant organisations in the
9 region, who are also service providers as well, so the
10 Royal Flying Doctors, for example, Marathon Health, so
11 there are other large agencies in the region. The RDN and
12 the PHN are probably the main organisations in terms of,
13 you know, that sort of collaborative planning work in - but
14 other agencies do do it as well.
15
16 Q. And in terms of - you said that there are
17 opportunities in that regard for more coordinated strategic
18 planning. What needs to change for that to be achieved, do
19 you think - in your opinion?
20 A. Yes, in my opinion - and this is probably quite a long
21 answer so I apologise in advance - I think if we take
22 a step back from who is responsible for what and, you know,
23 who provides what, and you think about the core services
24 that a community needs, and if you start with a core, you
25 start with a small community, you need access to good
26 comprehensive primary health care, you will need access to
27 community nursing, child and family health, palliative
28 care, aged care, urgent care - those core functions of
29 health care.
30
31 Then you might, within a region, like a smaller
32 subregion, need access to emergency care, maternity
33 service, obstetrics, ICU and a number of other functions,
34 and then within a state network, if you like, much more
35 specialised services as we have in New South Wales.
36
37 So I think to do that, you almost need an agreed
38 framework at a national level for the services that
39 a community needs within a reasonable proximity to where
40 they live, and then within a smaller network, and with
41 a larger network such as the state.
42
43 At the moment, to my knowledge, there isn't such
44 a sort of framework that outlines those principles at
45 a high level for the services that a community might need.
46 But that's probably one of the first things that would be
47 of benefit to a region like ours, even if it was only done

1 at a Western New South Wales level. That would be of
2 benefit to help understanding what health services really
3 need to meet the community needs.
4
5 Then you can go into your community and have a look at
6 what the health needs are, what are the demographics of
7 your community, what's the community saying is important.
8 Then you start putting the other bits back in: what's
9 there now, what do they offer, does that meet the need of
10 the community and what are the gaps and have a way to be
11 able to plan services with that whole landscape. At the
12 moment it's quite difficult to do that because there are
13 different funding sources for different programs - fly-in
14 services, clinics, health services that we provide, health
15 services the PHN may commission as well as private general
16 practice. So I think there is a real opportunity for
17 improvement here, but it does require thinking about things
18 a bit differently to the way we probably have in the past.
19
20 THE COMMISSIONER: Q. What you have just said, I think,
21 is a slight elaboration of what you have said in what is
22 both paragraph 45 and 46, for some reason, of your
23 statement; correct?
24 A. Yes.
25
26 Q. When you say there is an opportunity for stronger
27 state and Commonwealth planning on the framework for the
28 core services which you have just gone through, the word
29 "opportunity" is used in a number of these statements.
30 I take it by that, can I read "opportunity" as you think
31 there is a need?
32 A. Yes, I do think there is a need.
33
34 Q. Which I suppose is an opportunity as well, but "need"
35 might be the better word.
36 A. (Witness nods).
37
38 Q. And your opinion that there is a need for stronger
39 state and Commonwealth planning for all health services -
40 what I took from your answer before was there is so much
41 fragmentation in funding and so many different service
42 providers that there is perhaps a lack of coordination to
43 ensure that everything is matching up to what, in truth,
44 are the population health needs. Is that a fair summary?
45 A. That's a fair summary.
46
47 Q. And in terms of stronger state and Commonwealth

1 planning, give us your views on how you think that could be
2 achieved?
3 A. So I think that starts - obviously that starts at
4 quite a high level with your national reform agreements and
5 then follows down. I think you probably would need some -
6 Western New South Wales is probably a good region to
7 consider this in. You do need a way to have some agreement
8 where you will have an agency who will undertake that
9 planning work and people will agree and have input into
10 that to be able to get that robust assessment.
11
12 There is often talk of place based planning. That's
13 a component of this, but health services don't exist in
14 isolation, so you really can't plan a health service
15 without consideration of the network I mentioned before.
16 So you do need to have view to the local community, but
17 also what is available that is interconnected.
18
19 I think this would be an opportunity. I think the
20 time is now. This is particularly true in our small
21 communities and I'm sure you have heard evidence to this
22 effect. The biggest impact I think of fragmentation or
23 different service providers coming in, short-term funding
24 contracts, coupled with the challenges of getting
25 a workforce alongside declining populations and projected
26 decline means this fragmentation plays out most in our
27 smallest communities. It's not exclusive to the smallest
28 communities, but I think that's where it's the most
29 difficult.
30
31 Q. And I don't mean this unfairly to them, but is there
32 a sense of - or is there partly a self-interest with the
33 various service providers that perhaps gets in the way of
34 a holistic plan?
35 A. Perhaps.
36
37 Q. And how - I will take the "perhaps" as on the stronger
38 side of "maybe".
39 A. Noting that we are - Western New South Wales is
40 a service provider as well as doing planning, yes.
41
42 Q. What's the means of addressing that? Is it better
43 coordination between the funders and decision-makers?
44 A. I think that's a key part of it. Particularly when
45 you might get program funding for something that is
46 obviously a need, I'm not suggesting any of these things
47 are not related to needs, they absolutely are, but you

1 might get targeted funding that might be short term for
2 specific things and that, while meeting a need, does
3 contribute to some of that fragmentation as well. So you
4 would need tighter coordination between some of that and
5 how it applied, how it affects your particular region.
6
7 Q. Can you just help me also with let's call it
8 paragraph 45, in the sentence where you have said there are
9 opportunities for increased integration of services in
10 small communities, which is underpinned by stronger and
11 more accessible primary care - accepting that strong or at
12 least adequate, primary care is vital, it's probably vital
13 everywhere but it's particularly vital, perhaps, in rural
14 and regional areas where specialist care is harder to get
15 to, can you expand on the opportunities, or let's call it
16 the need for increased integration of services?
17 A. Yes, I can. So the MPS model has been around since
18 about 1990 and has been well recognised as a good model
19 that does provide high quality aged care and does get
20 I guess, if you like, some small economies of scale by
21 combining acute health services with residential aged care.
22 I think we're probably at a point in time where that model
23 needs to evolve, but evolve in different ways in different
24 communities.
25
26 So what you will see in some of our smaller hospitals,
27 for example, is a lower volume of emergency department
28 presentations or lower utilisation of the acute care beds,
29 but a high demand for residential aged care.
30
31 Q. Look, sorry to interrupt, but just to give you some
32 context, we've obviously been to a number of these MPSs,
33 and I'm not sure what the percentage would be, but the vast
34 percentage is as an aged care facility. So you are talking
35 about an evolution. What do you mean?
36 A. Yes, so I think --
37
38 Q. No doubt that's still necessary, the aged care aspect.
39 A. The aged care aspect will still be necessary and
40 probably necessary for the next 15 to 20 years, based on
41 the population demographics. After that, the need will
42 probably start to decline. The aged care, residential aged
43 care access is also impacted by the availability of
44 community home care, in people's homes.
45
46 Q. Why would the need decline for aged care?
47 A. There is essentially, you know, in very, very simple

1 terms, a bit of a speed bump in the population, if you
2 like, as the baby boomers age.
3
4 Q. There is obviously good data on this?
5 A. There is good data on this, yes. So I think if we
6 think about what our communities are going to need in the
7 future, noting what the population demographics are, some
8 of these smaller communities are projected to decline. We
9 know that their access to primary health care is not at
10 levels of attendance comparable to the state average, and
11 we know that is really important in keeping a community
12 well.
13
14 There is the potential to think about consolidating
15 services, whether that's an integration model,
16 collaborative model, and there's been some work done around
17 the concept of health places, which are essentially
18 a collocation of multiple services in one area. I think if
19 you took that broader view of health for a small community,
20 you would end up with a service that looked at the
21 comprehensive primary care needs, ambulatory care,
22 community nursing, aged care, palliative care, urgent care
23 when you need it, you know, other things that the community
24 needs, visiting mental health drug and alcohol services,
25 for example - really, really important in so many of our
26 communities. I think there is an opportunity to really
27 think about planning health places in some of these
28 communities where you look at the service offerings that
29 that community needs and whether or not they can be more
30 sensibly integrated, either physically collocated in the
31 community or under, you know, a governance model or
32 provided in a slightly different way.
33
34 Q. Can I also just ask you, given we're on this page,
35 going back to paragraph 44 where you have said there is an
36 opportunity for prevention and an emphasis on minimising
37 behavioural risk factors - accepting that there is always
38 a need for preventative care measures, which there might be
39 many, what do you have in mind in terms of that need?
40 I take it - I read that where it says "there is an
41 opportunity" - you tell me if I'm wrong, by the way,
42 because it is your statement, but where you say "There is
43 an opportunity for prevention and an emphasis on minimising
44 behavioural risk", I'm reading that as there is a need for
45 more.
46 A. Yes.
47

1 Q. Okay. Explain that.
2 A. So I think - if you look at some of the evidence
3 around what influences the health of a population, around
4 46 per cent are what we call the social determinants that
5 influence morbidity and mortality of a population. Health
6 care is about 17 per cent in some of the studies that have
7 been done and that includes acute and primary health care.
8 So if we want to make a difference in the health outcomes
9 of our communities, we absolutely have to look at this, and
10 so that's everything from health risk behaviours, smoking,
11 exercise, alcohol, to the social determinants of health -
12 housing, education, water, employment.
13
14 These things are really, really important to keeping
15 our communities well and healthy. So there is an
16 opportunity. This is not an easy thing to do. It does
17 require lots of government agencies and lots of people
18 working together.
19
20 Q. So it is whole of government for a start?
21 A. Whole of government, yes.
22
23 Q. And it's a cost but it is also an investment?
24 A. It is an investment, yes.
25
26 Q. Sorry, I interrupted you again. You keep going.
27 A. Oh, well --
28
29 Q. At a practical level, what would you have in mind? If
30 you were free to create within your role the best
31 preventative health planning framework for your community
32 and your LHD, what would you do?
33 A. So, I mean, as far as prevention goes - and there is
34 many other experts that I'm sure could probably give
35 detailed evidence on this, but some of the most effective
36 instruments is actually legislation, so - and obviously
37 that's not within the remit of the local health district to
38 create legislation, but Australia's been a really good
39 example of tobacco legislation, plain packaging
40 intervention, even seatbelt laws are a good example of
41 a public health legislation.
42
43 So there is an opportunity there. You know, I believe
44 a number of countries have adopted sugary beverages taxes
45 and things like that. So there is an opportunity at that
46 framework level.
47

1 Q. Do I take from that that obesity is a problem?
2 A. Obesity is a problem, it is a greater problem in
3 Western New South Wales than the New South Wales average.
4 So if we tackled obesity, for example, and did really
5 focused action even on obesity alone, we could reduce
6 rates. There is evidence to show that for every kilogram
7 of weight that you lose, you reduce your chance of getting
8 type 2 diabetes. So even if you picked one public health
9 measure like obesity alone and had a really concentrated
10 focus on, in a particular community, that would make a big
11 difference. Focusing on things like smoking and alcohol,
12 as I said, the smoking, in Australia, has significantly
13 reduced rates, but there is still more work to do in
14 Western New South Wales in that regard.
15
16 Even things that are in the remit sometimes of local
17 government or other agencies - footpaths, walking tracks,
18 sporting fields, green space, all of those things that
19 encourage a healthy active lifestyle do make a difference
20 to health.
21
22 The other things that are in the remit of other
23 government agencies, obviously education and schools,
24 employment and housing, all really, really important.
25
26 THE COMMISSIONER: Thank you.
27
28 MR FRASER: Q. Before we finish, I would like to ask you
29 some questions about community engagement?
30 A. Yes.
31
32 Q. Not just in relation to service planning but on
33 a broader basis. It is right, isn't it, community
34 engagement has a greater role than in relation to actual
35 service planning; is that right?
36 A. Yes, it does.
37
38 Q. You have said in your outline that in 2022 there was
39 a new approach adopted here within the Western New South
40 Wales Local Health District under what is termed the
41 meaningful engagement program?
42 A. Yes.
43
44 Q. And just in terms of community engagement, does your
45 team also do the community engagement for Far West, or is
46 that done locally within the district?
47 A. That's done locally within Far West.

1
2 Q. So in terms of your team, it's the strategic planning
3 aspect that - well, the health needs assessment I should
4 say?
5 A. Probably the most - the easiest way to describe that
6 is for Far West we do do that health of the population
7 report and we also provide some data and analytics,
8 performance type reporting functions for Far West. We
9 don't do their service planning and we don't do their
10 community engagement.
11
12 Q. Thank you. I should have clarified that.
13 A. That's okay.
14
15 Q. Moving back to community engagement, what was it about
16 meaningful - the meaningful engagement program that was
17 different to what was done before within the district?
18 A. So there was a number of drivers for this, but I think
19 probably to give you some history, in previous years, we
20 had a number of - every facility had a local health
21 council. Many of those evolved from health boards, which
22 were in place many, many years ago, and there is
23 a longstanding history of people volunteering in those
24 health councils. Some people have been on them for 20 to
25 30 years.
26
27 What we found, particularly exacerbated during the
28 COVID period, was that we were, in some locations,
29 struggling for attendance or, you know, community - members
30 of the health council and/or staff were reporting that they
31 weren't sure whether their committee was achieving
32 anything, so weren't necessarily considering it
33 a worthwhile use of their time. We also knew that we
34 weren't necessarily engaging in - with all of our
35 community, and our board - this was really, really
36 important to our local health district board as well. So
37 we took a new approach to see how we do that and how we
38 could do that and we wanted to test some new ways of
39 working.
40
41 There still are 14 health councils operational in
42 Western New South Wales, so that model does function well
43 for certain parts of the district, but not necessarily
44 everywhere. So what we tried to do was essentially create
45 a tiered model, recognising that you need to engage with
46 the community in multiple ways. At the middle of that is
47 local engagement and that can be a number of things. So

1 that might be a local health council, a group, it might be
2 local co-design projects, and that really is tailored at
3 that local level to meet the health service and the
4 community need.
5
6 At a subregional level, we wanted to set up some
7 committees that were a little bit more strategic, had
8 community members that represented the diversity of our
9 community and could come together to have a look at some of
10 those issues that were common across a collection of
11 communities, so having more of a planning and strategic
12 focus, and they are the two subregional committees that
13 I've mentioned in my statement.
14
15 Q. Can I just ask you, do they effectively cover half of
16 the district each or are they --
17 A. They cover about 11 locations for the district. So
18 we've got one in the north west and one around Dubbo and
19 surrounding towns as our first two engagement committees to
20 test and pilot.
21
22 Q. So that's a pilot that might be expanded; is that
23 right?
24 A. Yes, we're actually doing an evaluation of it at the
25 moment.
26
27 Q. In terms of the membership of those committees, can
28 you outline who the members are?
29 A. Yes. So we did an expression of interest process for
30 community members, so two community members from each
31 community that the subregional network covers. We have the
32 chairs of the Three Rivers and Murdi Paaki Regional
33 Assemblies as members. We invite the primary health
34 network, the Rural Doctors Network, the Department of
35 Education as well, to join those committees and be present,
36 as well as a number of our district staff, and some of our
37 local health district staff will attend at different times,
38 depending on whether they are engaging on a particular
39 topic or not.
40
41 Q. When will the evaluation be completed?
42 A. Later this year. So we have just been running focus
43 groups this month with some of the members.
44
45 Q. If you are able to say, do you have a sense of what
46 the feedback has been in relation to these committees?
47 A. Yeah. I have an early sense that the feedback has

1 been positive, that community members have felt that it was
2 a place where they can bring issues to and be heard and
3 that we were starting to see some tangible results. It's
4 only been just over a year of operation, and these things
5 do take time, to build trust with community members and to
6 distil the priorities that we can work on, but there is
7 early evidence that the committees have resulted in some -
8 both some specific local projects as well as some
9 priorities of probably broader importance like transport,
10 for example, that we will look to do some work on as
11 a committee.
12
13 Q. Just to bring this sort of back and connect with
14 strategic planning, does the information from these aspects
15 of community engagement feed back into strategic planning,
16 or at least will it?
17 A. Yes. It goes both ways. So we will - so, for
18 example, even just very local sort of projects, we've had
19 feedback around patients who have been transferred between
20 hospitals, which has resulted in a project that has come
21 out of that committee identifying that as a need; and we've
22 also had our planning team come along to talk to the
23 committee about some of the planning work that was under
24 way. We've had different parts of the organisation
25 developing plans or frameworks for their services come and
26 consult with these committees - so the oral health services
27 came to talk to these committees when they were designing
28 their plans, and that's really what we'll encourage more
29 and more of our staff to do, to use these committees both
30 as a consultation mechanism, but there are also some other
31 priorities for those committees that we will drive as well.
32
33 Q. Is it envisaged that these committees will take in
34 issues such as, for instance, services - well, you've
35 referred to transport as one that certainly has come out of
36 at least one of these committees, but additional services
37 that may assist the community?
38 A. To a degree. So far they've very much been around
39 I guess what I would call the health needs and the broader
40 health issues of the community. So the priorities that
41 have come up so far are things like transport, workforce,
42 including the ability to grow your own workforce and train
43 our own workforce from small communities. Mental health
44 comes up consistently. Services for children and family is
45 another thing that does come up a lot. And there is a bit
46 of variation between the priorities for the committees,
47 because they cover different areas, but these are

1 commonalities, I think, across all of them.
2
3 MR FRASER: Commissioner, those are the questions I had.
4
5 THE COMMISSIONER: Thank you.
6
7 Mr Cheney, do you have any questions?
8
9 MR CHENEY: No questions, thank you, Commissioner.
10
11 THE COMMISSIONER: Thank you very much for coming in,
12 Ms Hawthorn, we're very grateful for your time. You are
13 excused.
14
15 **<THE WITNESS WITHDREW**
16
17 THE COMMISSIONER: That's 10 o'clock tomorrow?
18
19 MR FRASER: That's my understanding. I'm getting the nod.
20
21 THE COMMISSIONER: We'll adjourn until 10 o'clock
22 tomorrow.
23
24 **AT 4.35PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
25 **TO THURSDAY, 16 MAY 2024 AT 10AM**
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